07-04765 Kianna Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

IIIIa Joiliison		- For State	Certifica	ite of Death	Reg. I		
Physicia		Registrar 1. Decedent's Name (First, Middle, Last	:)		Date of Death Month Da		3. Time of Death 1502 hrs
dical Exami	ner	KIANN	A	JOHNSON	Month Da June 22, 200	7	1502 1115
		4a. Facility Name (if not institution, give	e street and number)	4b. City, Town, or Location of I Baltimore	Death	4c. County of Death	
*		Johns Hopkins Hospital			24Hrs. 8. Date of Birth (AM/DD/YYYY 9. Birth	place (State or
Funeral Director		5. Social Security Number 6. Se	. ^	Months Days Hours	Min. A CA 23	Foreign	
Director	ļ	591-65-4700 1 Usual Residence of Decedent	M 2XF / /	Yrs.	UCCIAC	1110	1 LUNILI
any	ŀ	10a. State 10b. County	10c. City, Town	or Location	α		10d. Inside City Limits
À .	_	MADWAIN	JA	BALTIMO	DRE CI	TY	1 X Yes 2 No
15-0036 High within 72 hours after death with the Maryland Highener Han "natural", or items 23a or 28a-f show i, she Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	try?
the Na or Sa or	ä	1527W. FA	HRMOUNT AVEN	UE 212	23	14. Race - Americ	ean Indian Black
h with	era	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F 	Puerto Rican, etc.)	White, etc.	all Ilidali, block,
r deatl	핊	_	1 Yes 2 No	1 Yes 2 X No specify:		Specify: Pl	ACK
rs afte ural", miner	b	3 Widowed 4 Divorced 15. Decedent's Education (Specify of	nly highest grade completed) 16a	Decedent's Usual Occupation (Give king	nd of work done	6b. Kind of Business/li	ndustry
2 hou	eted	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of working life. DO NOT u	se retired)	10	S
5-0036 iled within 7 Hygiene. I other than	Completed	4 THGRADE		STUDENT	Name (First, Middle, Ma	ELEMEN	TARY CHOOL
5-0 lled w Hygie I othe		17. Father's Name (First, Middle, Last	(UNKNOWN)	18.Mothers	Name (First, Middle, Ma	TO HA	ISON
2121 ould be fi Mental I marked	o Be	19a. Informant's Name/Relationship (Type Print) 19	b. Mailing Address (Street and Numb	per or Rural Route Number	er, City or Town, State	, Zip Code)
MD 21215-003 d 2 should be filed within the and Mental Hygiene. n 27 is marked other th	ř	SOUTA CHAV	S (AUNT)	106 SUNMAR	CT. BA	TIMORE,	MD21201
and 2 and 2 lealth item 3		20a. Method of Disposition		of Disposition (Name of cemetery, tory or other place)	Date	20c. Location - City or	Town, State
MOF6 Pages 1 rent of h			Removal from State	TERN CEMETERY	26-27-07	BALTIMO	RE, MD
Baltimore, permit Pages I a Department of He Important: If it injury or other t		4 Donation 5 Other Specification 21. Signature of Funeral Service Lice		22. Name and Address of Facility	BROWN	TR, FUNE	EAL HOME
ii Ing		Dietich	1. Williams	2140 N. FUL	TON AVE.	SALTO,	Approximate Interval
Ph ician		failure. List only one cause on e		ot enter the mode of dying, such as ca	relac of respiratory arres	it, shook, or flear	Between Onset and Death
/Medical aminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):				
<i>J.</i>).				
	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):				
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):				
and and transit			d				
e exe cian rial	1 ()	UNPENDED	AMENDED			23d. Date of delive	
760 ficate b g physi		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy 1 Live birth	y 2 Fetal death 3 Ectopic	: pregnancy		Day Year
Box 687 E death certific the attending I ed for use as the	Physician/	past 12 months?	4 Pregnant at time of death	5 Other (Specify)			
BOS e death the att	hysi	1 Yes 2 No 9 Unknow	011111101111	to the standards in a possession in Pa	ut I 23e Did tol	pacco use contribute to	the cause of death?
; P.O. Box 687 ires that the death certific is signed by the attending.	by P		s contributing to death but not resulti	ng in the underlying cause given in Fa			bably 4 Unknown
S, F puires in sign		11			24a. Was a		utopsy findings available
ords, aw requir nas been s	ompleted				autops perfor	med? death?	
tal Reco cian: The law certificate has	S			26.Place of Death	(Check only one)	2 No 1 🗸 `	res 2 No
Vital Recc ysician: The lar his certificate ha director page 2	BB	25. Was case referred to medical examiner?	Hospital: 1 ✓ Inpatient 2 ER/	Outpatient 3 DOA Other		Residence 6 Oth	er:
n of Vital Records, ling Physician: The law requir After this certificate has been is finneral director nase 2 should l	 ⊢	27 Manner of Death	28a. Date of Injury 28b	o. Time of Injury 28c. Injury at Work	c? 28d. Describe h	now injury occurred	
ion o tending eath. for: Aft	<u>.</u>	1 Natural 5 Pending	9	50 hrs 1 Yes 2 ✓	NO	struck by auto	
Division tal or Attendi us after death. al Directors led in by the fi	Certification:	2 Accident Investig 3 Suicide 6 Could n	28e. Place of Injury - At home.	farm, street, factory, office building, e	tc. 28f. Location (S or Town, S	Street and Number or f tate) Baltimore Street, Ba	Rural Route Number, City
Div ospital o hours af	ا ا	4 Homicide determi	ned (Specify) Local Street				
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifications after death. To the Funeral Director. After this certificate has been signed by the attending Internation thinks the funeral director maps. 2 should be deached for use as it.			sician: To the best of my knowledge, oner:On the basis of examination and/o	death occurred at the time, date and plor investigation, in my opinion, death of	ace, and due to the caus ocurred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
Dj. To the Hospital of within 24 hours a To the Funeral Learneral	Medical	29b. Signature and title of certifier	and manner stated.	29c. License number		29d. Date signed (A	
_	12	ALL ASSISTANCE AND THE OF COLUMN		O.C.M.E.		June 24, 2007	
V X	1	30 Name and address of person w	no completed cause of death (Item 23a	a)			
15			tant Medical Examiner 11	1 Penn Street, Baltimore, MD	21201		
	Stat		32 Registrar's Signature	pode			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physicia		. Decedent's Name (First, Middle, Last)		rtificate of Deat		. Date of Death Month	Day Year	3. Time of Death					
/Medic		Martha Garrett Jackson					1, 2007	11:40 A					
Examin		a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location			4c. County of Dea						
		Casey House 5. Social Security Number 6. Sex 7. Ag	je (In yrs. last birthday)		rwood der 24 Hrs. 8	. Date of Birth (Month, Day,	Montgor	rthplace (State or Foreig Country)					
Funeral Director		480-20-1690 1□ M 2KQ F 83 Usual Residence of Decedent	~ 4	Months Days Hou	rs Min.	02/01/	(1923 I	A					
at at	-	Oa. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits							
a-f sh iffied	Sto	MD Montgomery	Bethesda	a				1 □ Yes 2 🔼 N					
or 28 e not	Öie	Oe. Street and Number		10f. Zip Code		10	g. Citizen of What C	Country?					
s 23a nust b	ral	8012 Greentree Rd.	Ever in II S 13	20817 –	Origin? (Speci	fy Yes or No-	USA 14. Race - Am	nerican Indian,					
S I all the Should be fine within 12 thous and local min the may have I Health and Mental Hele. 1 Faith and Mental Hele. 1 Faith and Mental Hele than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	골	11. Marital Status 1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced 12. Was Decedent Armed Forces? 1 □ Yes औ □ If Yes, Give Year or Dates:	No No	Was Decedent of Hispanic If Yes, spedfy Cuban, Mex 1 ☐ Yes 2☑ No Spec		can, etc.)	Black, Wh						
natural lical Ex	Be Completed by	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during i DO NOT use retired)	nost of working	7 1	6b. Kind of Busines Own Home	•					
the Med	mple	Elementary/Secondary (0-12) College (1-4or 5	5+ì I	DO NOT use retired) emaker	·		Own Home						
al Hygie	ပ္မို	17. Father's Name (First, Middle, Last)		18. M	other's Name (First, Middle, M	laiden Surname)	-					
Aental rked c	P B	Neill Garrett		V .	Vinona P	earl Jor	ies						
uth and Mental be set is marked of r traumatic eve		19a. Informant's Name/Relationship (Type. Print) Robert Jackson/Son		ng Address (Street and Nu 22 Ariel Ct.									
		20a. Method of Disposition 1 ☐ Burial 2/A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		osition (Name of smatory or other place) eake Cremator		Jun 25 2007	Beltsvill	or Town, State					
permit. Prage Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-											
Medical u and and al-transit	al Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Due to (or											
oe iciar buris	<u>.</u> 2	d											
the death certificate be executed y the attending physician and tched for use as the burial-transit	nysician/Medical		2 ☐ Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of o Month	delivery Day Year					
jures that the death certilicate be et n signed by the attending physiciar ild be detached for use as the burit	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 23C. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 ☐ Fetal death 3[at time of death 5[Other (specify)	Part I.		Month sacco use contribute	Day Year					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Joan 200 June /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner he sapeake Medical Center Hartoro Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month), Day, 12/17 Social Security Number 1 M 2 KF Days Hours BALTIMORE, MD **Funeral** Months Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 1 ☐ Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must be notified. Director MD Har 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2101 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 2 No 1 🗆 Yes Baltimore, Maryland 21215-0036 Whit Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) nomemake 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be shot 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2856 SON Sharo 20c. Location - City of Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 6/25/07 Foresthil MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility & New Port Dr., Forest HILMO 21050. 21. Signature of Funeral Service Licensee Evans Funcial Chapel - Cremation Services-Balder Composition on Constitution o 23a. Part1, Enter the dise shock, or heart failur Immediate Cause (Final disease or condition resulting in death) trace Physician /Medical Due to (or as a consequence of) Examiner a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 ☐ Other (specify) completely filled in by the funeral director, page 2 should be detached 9∏Unknown been signed by the 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 XNo 24a. Was an autopsy performed? 1☐ Yes 2 No 1∐ Yes To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Medical Certification: To Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) a.thot 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 29a) (Type, Print) peque 19 2. Registrar's Signature 31. Date filed (Month, Day) (ear)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla	•	rtificate of D		-	Reg. No.	07	2050+	
ľ	Dhusial		1. Decedent's Name (First, Middle, Last)					2. Date of De	ath Day	Year	3. Time of Death	_
	Physicia /Medic	_	Hilda			Keaton		June	22 2	2007	7:00p. M	
1	Examin	er	4a. Facility Name (If not institution, give st.			4b. City, Town, or I			4c. Cour	nty of Death		
e	<u> </u>		Haven Nursing H 5. Social Security Number 6. Sex		rs. last birthday,	Balti If Under 1 Year	More If Under 24 Hrs.	8 Date of Rid	th	0 Riether	lace (State or Foreign	_
	Funeral Director			M X□F 82	Man	Months Days	Hours Min.	8. Date of Birl (Month, Da	y, Year) 1 25	Cour	MD	
	land ow	ŀ	10a. State 10b. County	10c.	City, Town or L	ocation				1	0d. Inside City Limits	
	Many a-f sh fled	ţċ	MD Baltim	ore	Pik	esville					1 ☐ Yes 2 🙀 No	
	or 282 e not	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cour	ntry?	
	23a ust b		7121 Walnut Ave				.208			.S.A.		
	er de	Funeral	T. Markar Olaras	2. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of His If Yes, specify Cuban	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. F	Race - Amerio Black, White,		
30	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notifiled at	by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1□Yes 🏋 No	Specify:		Spe	cify: Bl	ack	
9500-612	'2 hou	ted	15. Decedent's Educa (Specify only highest grade	ation	16a. Dece	edent's Usual Occupa	tion	ing	16b. Kind of	Business/In	dustry	Ī
2	ithin 7 ne. nan "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	- 1	kind of work done du DO NOT use retired)		ing	Ъ.		_	
7	led w lygier her th		12th grade	na		Seamstres		o /First Middle		rivat	e 	_
yland	ntal F ed otl ever	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		, ivialden Sum	iame)		
	hould id Me mark matic	2	John Thomas Shace 19a. Informant's Name/Relationship (Type			ing Address (Street a	Iola Je		er City or Toy	vn State Zir	Code) 21133	_ ฉ
Za	than		Karen McKenzie-N	,		•					town, Md	ر
ē,	s 1 ar f Hea ftem (20a. Method of Disposition	20		osition (Name of ematory or other place		Date		n - City or To		_
Ē	Page nent o nt: If Iry or		1X Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State		d Ridge		9/07	Pike	svill	e, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensed	K- Done	P	2. Name and Address March F/F 4300 Waba	H West	D ~ 1 +	imoro	, Md	21215	
	5300		23a. Part1. Enter the disease, or complic	ations hat caused the d						, Hu_	Approximate Interval Between	_
	Physician		shock, or heart failure. List only one Immediate Cause (Final disease or condition	Atheruse	laster	Cardios	beer la	· di	56956		Onset and Death	
	/Medical		resulting in death)	Due to (or as a con		(areno)	(d) Call		2 (12 (`		_
	Examiner	L	Sequentially list conditions, b.	Demer	Hig					_		
	led sit	nine	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a con	sequence of):							
	execut and al-trar	Examiner	that initiated events c. resulting in death) Last	Due to (or as a con-	sequence of):					-		_
68/60 ,	rtificate be executed ng physician and as the burial-transit	calE	d.									
å	7 00	Medical										
X 20 20	death cer e attendir d for use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome pf pre 1 ☐Live birth 2 ☐ F		□Ectopic pregnancy				Date of deliv	*	
	w requires that the death cer been signed by the attendin should be detached for use	Physician/	1 Yes 2 No	4□Pregnant at time 9□Unknown	of death 5	Other (specify)				Month	Day Year	
7.	requires that the een signed by th nould be detache		Part II. Other significant conditions cont	ributing to death but not	resulting in the	underlying cause give	n in Part I.	23e. Did t	obacco use c	ontribute to t	he cause of death?	_
cords,	uires signe d be	d by	v	Ü	Ü	, ,					bably 4 🗷 Unknown	
Ö	law req as beer 2 shou	lete						24a. Was	an 24	lb. Were auto	opsy findings available	
Ě	0 5 0	Completed						auto- perfe	psy ormed?	prior to co death?	mpletion of cause of	
VII		0	25. Was case referred to medical				26. Place of Deat		2 🗷 No	1 □ Yes	2 No	
	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No	ospital:	2 □ ER/Outpatie	ent 3□DOA Othe	er.	ome 5□Resi		Other (Speci	fy)	_
n or	ding Physician: n. After this certific funeral director,		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	z8b. Time	of 28c. Injury Work	at ?	28d. Describe	how injury occ	curred		
210	r Attending er death. rector: After by the funer	catio	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				res 2□No					_
DIVISION	tal or Atten s after deatl al Director: ed in by the	Certification:	4 Homicide determined	28e. Place of injury - A building, etc. (Sp	At home, farm, s necify)	treet, factory, office		28f. Location (City or To	Street and Nu wn, State)	ımber or Run	al Route Number,	
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in the	ledical (29a. Certifier (Check only one) 1	cian: To the best of my er: On the basis of exar and manner stated.	knowledge, dea nination and/or i	th occurred at the tim nvestigation, in my op	ie, date and place, pinion, death occur	, and due to the rred at the time,	cause(s) and date and place	manner as s ce, and due t	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License			29d. Date sig		-	_
	4		Bondyn M1	Yacan	MD	_ D19	5503	3	JUN	€ 26	2007	
1)	3 1	1 19	30. Name and address of person who cor	npleted cause of death ((Item 23a) (Type	LPHIN S	ST, B	ALTI	MOR	EM,	DalaA	
Ē	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's S		200						_

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State of Maryland / Department of Health and Mental Hygiene

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		30. Name and address of person who co	Polle mo			O.C.M	1.E.		June	20, 2007		
To the Ho within 24 To the Fu completel	Medical	one) 2 Medical Examiner:	On the basis of examination and and manner stated.	/or investiga	ation, in my o	pinion,	death occurr	red at the time, o	date and place	e, and due to	the cause(s) Month, Day, Year)	
spi hou ner		4 Homicide determined 29a. Certifier 1 Certifying Physicia	n: To the best of my knowledge	1212 F	laverhil and	manner as st	altimore, MD					
ivisic	Certification:	2 Accident Investigatio 3 Suicide 6 X Could not b	28e. Place of Injury - At home	e, farm, stre		_		28f. Locati	on (Street and	d Number or	Rural Route Number, City	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the raper death. al Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detactly	tion:	27. Manner of Death 1 Natural 5 Pending	(Month, Day, Year)	8b. Time of FND 8:1			at Work? es 2 X No		ibe how injury	у оссипеа		
f Vit; Physician this contained	입	1 ✓ Yes 2 No		R/Outpatier				ursing Home 5		ce 6 V Oth	ner: Scene	
Vital Rec ysician: The his certificate director, page	Be Co	25. Was case referred to medical			26			eck only one)	63 Z NO		160 Z NU	
e faw re	mple							_ a	utopsy erformed? es 2 No		o completion of cause of	
ords, P	Completed by							_	Yes 2	24b. Were	robably 4 ✓ Unknown autopsy findings available	
O. E hat the ded by the detached		Part II. Other significant conditions	contributing to death but not res	ulting in the	underlying o	ause giv	ven in Part I.				to the cause of death?	
Box 61	Physicia	1 Yes 2 No 9 Unknown	4 Pregnant at time of deati		other (Specif	y)						
6		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna	псу	etal death	з [Ectopic pre	egnancy	- 1	Date of delive lonth	ery Day Year	
8760, tificate be executed ng physician and as the burial - transit	n/Medical	X UNPENDED	AMENDED, 27, 28a-f, p	erME, g	3868, 6/	27/0	7 TT					
cuted nd transit		events resulting in death) Last D.	ue to (or as a consequence of):			_						
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	اير	Sequentially list conditions, b	ue to (or as a consequence of):									
Examiner		Immediate Cause (Final disease or condition resulting in death)	Mixed drug (other use to (or as a consequence of):	nol. c	caine,	OXVO	olore.	and diazo	pem) int	oxicati	Death	
Physician /Medical		23a. Part I. Enter the disease, or compli- failure. List only one cause on eac	cations that caused the death. D	o not enter	the mode of	dying, si	uch as cardia	ac or respiratory	arrest, shock	, or heart	Approximate interval Between Onset and	
Balt permit. Departu Import injury		21. Signa in all Fyneral Service License	1	²² A 1	Name and A MDrose 328 St	Fui Fui	neral	Home,]	nc.	itus N	4D. 21227	
Pages Pages nent of ant: I		1 Burial 2 X Cremation 3 4 Donation 5 Other Specify:	Wes	rema	atory	06-25-	07 C	dentor	n, MD			
and and Healt trau	-	20a. Method of Disposition			sition (Name			Date			or Town, State	
Z = 8 = 5		19a. Informant's Name/Relationship (Tyr Donna Murphy, II			ng Address Westsh			or Rural Route Baltimo				
21215-0036 Juld be filed within 7 Mental Hygiene. marked other thau	Be	William G. Leor		K. Muri	hy							
-003(l within giene. ther tha	omo	12 17. Father's Name (First, Middle, Last)	1	Tru	ck Dri	ver	Mother's Na	ame (First, Midd	Tr le. Maiden Su	anspoi	rtation	
5-0036 ed within 72 hours after tygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		nost of working				Tob. Kill	2 of Ductiness		
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th the M 23a or 2 aotified		302 Westshire Rd.		1		229			USA		District Plants	
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	Ŀ	Usual Residence of Decedent	2 1	Yrs				Tare	11 10,	17//		
Funeral Director		5. Social Security Number 6. Sex 216-11-8177	7. Age (In yrs. last		If Under	Year Days	If Under 24	-	`	1Fore	irthplace (State or iign country) MD	
		4a. Facility Name (if not institution, give 1212 Haverhill Road	street and number)		4b. City, Tov Baltimo		cation of De	eatn	40.0	N/A	tn	
Medical Examin	er	Jason Christoph			41 Oliv. T-		and and Do	June 20		Year ounty of Dea	0822 hrs	
Physicia	E	- For State Registrar 1. Decedent's Name (First, Middle,Last)	Certii		Reg. No. 2. Date of Death 3. Time of Death							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mary T. Lijewski 19, 2007 10:22 June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Months Hours Min. 1 ☐ M 2 ☐ F Director Oct.24. 1919 N.C 243-28-6079 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State r 28a-f show notified at 10b. County 1 ☐ Yes 2 ☐ No Director MD Baltimore N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number than "natural", or items 23a or the Medical Examiner must be <u>21128</u> USA 4316 Silver Spring Rd. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygient Important: If item 27 is marked other tha any injury or other traumatic event, the 1 once. Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Johnson Paul Totten ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Edward Lijewski/Husband 4316 Silver Spring Road, Perry Hall, Md. 21128 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/25/2007 Baltimore, Md. Bayview Crematory 22. Name and Address of FacilitySchimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road, Nottingham, Md. 21236 ucir a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 24 hous Due to (or as a neequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Unsease or nijery) that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 本 and burial-tra Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 ☐ Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed es 2 certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient 2 ER/Outpatient 3 DOA 1 Tyes 2 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? After t Certification: (Month, Day Year) Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Definiting Physician: 10 the best of his knowledge, deal received at the time, date and piece, and due to the cadas(s) and manner as date.

□ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending within 24 hours after death. To the Funeral Director: After

State

29b. Signature and

title of certifier

Year)

6

(Month, Day

ddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar

DHMH 17 Rev 1/2001

29c. License number

063830

29d. Date signed (Month, Day, Year)

07-04770	
Randy Livingston	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Reg. No Registrar Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day June 23, 2007 0215 hrs Livingston Medical Examiner Emmanuel Randy 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital 8 Date of Birth/MM/DD/YYYY 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Days Hours 05 19 87 MD Country) Director 20 1Х м 2 214-15-1979 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a, State X Yes 2 No Baltimore s 23a or 28a-f show notified at once. 28a-f show NA MD death with the Maryland Director 10g, Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 21216 2030 Ruxton Ave 14 Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status or items must be White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes Black 1 Yes 2 X No specify: Specify Divorced If Yes, Give Year Widowed "natural" Ş 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. event, the Medical If item 27 is marked other than Sams Club Sales Associate na 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rena Atkins Be Eugene Livinston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2030 Ruxton Avé, Baltimore, Md 21216 Rena Atkins-Mother 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) or other X Burial 2 Cremation 3 Removal from Stat Md 6/29/07 Randallstown, Memorial Park Important: King Donation 5 Other Specify 22. Name and Address of Eacilit March F/H We 4300 Wabash ture of Funeral Service License st Ave, 21215 Baltimore, Md Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval 23a. Part I. Enter **Physician** Between Onset and Death /Medical a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and cal AMENDED UNPENDED e attending physician for use as the burial Physician/Medi Box 68760, The law requires that the death certificate be 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Month Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 0.0 certificate has been signed by ector, page 2 should be detached Yes 2 ✔ No 3 Probably 4 Unknown ģ Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 ✓ Inpatient 2 Other Nursing Home 5 Residence 6 ER/Outpatient 3 DOA this ٩ 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury After 27. Manner of Death Certification: Driver auto fixed object collision Jun 22, 2007 2125 hrs 1 1 Yes 2 ✔ No Natura Pending To the Funeral Director: completely filled in by the 2 🗸 Accident 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 2600 Gwynns Falls Parkway, Baltimore, Md. 3 Could not be Suicide (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier June 23, 2007 O.C.M.E. تعلين 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. Assistant Medical Examiner 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registra

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 3:05 AM Sun Kyoung Lee JUNE 2007 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death BALTIMORE WASHINGTON MEDICAL CENTER ANNE HRUNDEL BURNIE GLEN If Under 1 Year If Under 24 Hrs. Nonths Days Hours Min. (Month, Day, Year) 04-15-1929 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign
Country) 1⊠M 2□F 78 Yrs. North Korea 212-74-1636 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 658 Faircastle Ave. 21146 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔁 No If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 0wner Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jung Shik Lee Hong Bong Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 658 Faircastle Ave; Severna Park, MD 21146 Mr. Eric Myong Lee / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date June 26, 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Cemetery 2007 Marriottsville MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, PA MO1459 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Gastrointestin Blesding Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Chronic 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Anpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No 2 ER/Outpatient 3□ DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) t Natural 5 Pending 1 Yes 2 No М 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

/Medical Examiner physician and To the Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, death.

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/Medical

Examiner

Funeral

Director

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Director

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Pages 1 and 2 should be filed within 72 hours after death ment of Heelth and Mental Hygiene.

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Baltimore, Maryland 21215-0036

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State Registrar

31. Date filed (Month, Day, Year)

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29b. Signature and title of certifier

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30. Name and addr

ess of person who completed cause of death (Item 23a) (Type, Print) 32. Reistrar's Signature

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29d. Date signed (Month, Day, Year)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DHMH 17 Rev 1/2001

Registrar

JUN 2 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** John Francis Muszynski 22 2007 June 12:15a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Aug. 26, 1953 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 213-64-8461 Mary Tand Director Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? is 1 and 2 should be filed within 72 hours after death with of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 4710 Kenwood Avenue 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Maryland Speciality Elementary/Secondary (0-12) College (1-4or 5+) Warehouseman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Francis Muszynski, Sr Joy Appelt 19a. Informant's Name/Relationship (Type. Print) Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Mangieri Muszynski 4710 Kenwood Avenue-Baltimore, Maryland 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If a ō June 27,2007 Parkville, Maryland Parkwood Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 8800 Harford Road EVANS FUNERAL CHAPEL AND CREMATION SERVICES Parkville,MD 21234 -condine ter Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consec Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the burial-tran Due to (or as a consequence of): physician IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Probably 4 ☐Unknown 1 ☐ Yes 2 ☐ No page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 201 No 102 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 ed by the a signed to certificate Physician: this After Hospital or Attending death. within 24 hours after death

To the Funeral Director:
completely filled in by the

Pages 1

Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of cert

lame and address of person who completed cause of death (Item 23a) (Type, Print) JUN 2 6



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 3 Mostey 2 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Maryland Medical System 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months 1**≰** M 2 □ F 214-64-0095 Usual Residence of Decedent Director 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a. State 10b. County 1 ZYes 2 No Director MDtimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code dden Completed by Funeral 12. Was Decedent Ev. Armed Forces? 1 ☐ Yes 2 No. If Yes, Give Year or Dates: Race - American Indian, 13. Was Deceden If Yes, specify nt of Hispanic Origin? (Specify Yes or No-Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) State a lorke Be ဂ 19a. Informant's Name/Relationship (//pe. Print, Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or ItO.MD 212L).Masler) Fe 20b-Place of Disposition (Name of cemetery, crematory or other) Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) emeter 21. Signature of Funeral Service Licenses Mo 1363 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 4009 Cancer /Medical Due to (or consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending p for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No director, page 2 : autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural
2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 7 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar

31. Date filed (Month, Day, Year) JUN 2 6 2007

22 South Greene

ress of person who comple



d cause of death (Item 23a) (Type, Print)

M.D

MD 21201 Eric Schwartz Baltmore

19825

06-33-3067

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	Dharaisi		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Yeer	3. Time of Death				
	Physici /Medic		Eleanor B. Melekog					June	23, 200	07	8:30 P M				
7	Examin	er	4a. Facility Name (If not institution, give st		7		r Location of Death		4c. County						
			Washington Adventi		(In yrs. last birthday)	Takoma I	If Under 24 Hrs.	9 Date of Bir	Monte						
	Funeral Director			M 2∏F	78 Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da AUG 29	iy, Year) , 1928	Ohi	place (State or Foreign htry)				
	nyland show		10a. State 10b. County		10c. City, Town or Lo	ocation	-			1	0d. Inside City Limits				
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	with the		10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	itry?				
	e 23a	a la	1415 Ruatan St	2. Was Decedent E	was in II C 12	20783	liannia Osiaia2 (Ca	and Van as No	USA 14 Pag	e - Americ	on Indian				
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health end Mental Hygiene. If Item 27 Is marked other then "naturel", or Iteme 23a or 28a-f ehow or other traumatic event, the Medical Examinar must be codified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 Yes 2 XN If Yes, Give Year or Dates:	0	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	Rican, etc.)	Bla	ck, White.	etc.				
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Maryland	12 sh h end 7 ls n traun		19a. Informant's Name/Relationship (Typ Ali Melekoglu/Hush		1	ng Address <i>(Street</i> Ruatan S			-		Code)				
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o.	requires that the death certificate be executed seen signed by the ettending physician and hould be detached for use as the burial-transit	Physician/M	t □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at t 9□ Unknown	ime or death 5 L	Other (specify) _			12		·				
<u>α</u>	that hed by deta	y Ph	Part II. Dthen significant conditions cont	ributing to death by	t not resulting in the u	gderlying cause giv	en in Part I.	23e. Did t	tobacco use con	tribute to th	he cause of death?				
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ita	ysicien: The l is certificate he director, page	BeC	25. Was case referred to medical examiner?		/		26. Place of Deat								
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	To the Hospital or Attending Ph within 24 hours aftar death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Physic (Check only 2 Medical Examina	cian: To the best of	f my knowledge, deat	h occurred at the tim	ne, date and place,	and due to the	cause(s) and made	anner as s	tated.				
	the H hin 24 the F nplete	Medical	Unity (and manner stat	ed.			. 50 21 110 11110,							
\	To Tour	-	29b. Signature and title of certifier			29c. Licens	- / / / -	7	29d. Date signe	η (Month,	Lay, rear)				
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1	5		30. Name and address of person who con	npieted cause of de	atn (Item 23a) (Type,	Print)	1.	<u> </u>	Spring	· da	2/50.7				
	Sta	te	31. Date filed (Month, 1944) 2007	32 Registra	's Signature	CALACA	LC MUC,	SLVER	SORING	7, 101	2716				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year Sharhonda, Minter /Medical 20 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Manyland Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. Jast birth Baltimore f Under 1 Year | If Under **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Year) 1 M 2 M Months Days Hours 60 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Md. 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married ☐ Yes 2 Yes, Give 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Specify Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industr (Give kind of work done during most of working life_DO NOT use retired) Elementary/Secondary (0-12) Coffege (1-4or 5+) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OVON E ပ 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) maris 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 30~0 Carmel Com 4 Donation 5 Dother (Specify) 21. Signature Funeral Service Ucenser Op, md, 2/220 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mone of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Pulmonary H Due to (or as a consequence of): disease or condition resulting in death) lty pertension 6 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed Be (ဥ Certification:

The law requires that the death certificate be executed attending physician and for use as the burial-trar Division or Vital Records, P.O. Box 68760, signed by the a this certificate h To the Hospital or Attending Physician: within 24 hours after death

o the Funeral Director:
completely filled in by the

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

and Mental Hygie is marked other

Physician

/Medical Examiner

						Щ	1 ☐ Yes 2 [No 3 Probably 4 Unknown
	_						24a. Was an autopsy performed? 1 Yes 2 □ No	24b. Were autopsy findings available prior to completion of cause of death? 1 N es 2 □ No
25. Was case reference examiner?	rred to medical				26. Place of De	ath (C	Check only one)	
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27. Manner of Dear 1 ✓ Natural 2 ☐ Accident	th 5	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Worl	at		I. Describe how injury	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At h building, etc. (Speci	ome, farm, street, fa fy)	actory, office		28f.	Location (Street and City or Town, State)	Number or Rural Route Number,
29a. Certifier (Check only	1 ☐ Certifying Ph 2 ☐ Medical Exan	ysiclan: To the best of my kno niner: On the basis of examina	owledge, death occurrence	urred at the tir	ne, date and place	e, and	I due to the cause(s)	and manner as stated.

29b. Signature and title of certifier

June 20

2007

29c. License number 29d. Date signed (Month, Day, Year)

17471

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 South Greene St, Baltimore MD,

State Registrar

Medical

State Registrar 31. Date filed (Month, Day,

JUN 2 6 200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** 2007 Hermisenda Miller June 9:55 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Health of Glen Burnie Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M Yrs 261-89-6018 86 Director 09/03/1920 Rep. of Panama Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes XXX No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 NE 6th Avenue 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXXNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 200 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2 No Specify. þ 3 Widowed 4 □ Divorced Panamanian Hispanic Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Professor University Department of Health and Mental Inginity in Ingertant of Health and Mental Hygin Ingortant: If Item 27 is marked other any Injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugenio Huerta Hermisenda Guillen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Nick Lancaster / son 18014 Foreston Road, Parkton, Maryland 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/26/2007 Chesapeake Cremation Stevensville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. Second Ave, MO1357 SW Glen Burnie, MD 21061 mucu 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and D Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** do MEA /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
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To the Funeral Dire
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DHMH 17 Rev 1/2001

Registrar

knownas: Jacoba

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per doc 2868 6-20-07 vt. State of Maryland Department of Health and Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year Acob **Physician** mc LAughlin 754 0 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Itospita BAlTimore SiNai BAITIM 8. Date of Birth (Month, Day, ff Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday)
Yrs. Birthplace (State or Foreign County) **Funeral** Months Days Hours Min 48 1270 M 2□ F 230 4 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f ehow traumatic event, the Medical Examiner must be notified at 12Nes 2□No Director BALTI mone 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "naturel", or iteme 23a 2/23 State) 5 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married BIK Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: þ Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) Coflege (1-4or 5+) 17. Father's Name (First, Middle, Last) (First, Middle, Maiden Sumame) Be Walter MC LAugh/in 19a. Informant's Name/Relationship (Type, 19b. Mailing Advress (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Heelth a important: If item 27 is any injury or other traisons. Brother 525 CA 30022 navetta Baltimore, 20a. Method of Disposition 20c. Location - City of Town, State 20b. Place of Disposition (Name of 1 Burial 2 □ Cremation 3 □ Removal from State Bloxan MACadenia 4 ☐ Donation 5 ☐ Other (Specify) Cem 07 FUNCTE 21. Signature of Funeral Service Licensee CLUMAC 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat YDIOVASOU/A Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially fist conditions, if eny, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine ed by the ettending physicien end detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Director: After this certificete in by the funeral director, pag 1 ☐ Yes 2 € No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 25 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ۲ 2 Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. fnjury at Work? Medical Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending death. 1 Tes 2 No investigation 6 Could not be determined 3 Suicide within 24 hours after de To the Funerei Directo completely filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of fnjury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Destrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (tiem 23a) (Type, Print) mont Would 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ANNE MILLER	Baltimore, Maryland 21215-0036
•) is
	68760,

Division of Vital Records, P.O. Box

_	for State Registrar	State of	f Maryland	•	ficate of L		vieritai i i	Reg. No.	007	2051				
	1. Decedent's Name (First, Middle	e, Last)					2. Date of D	eath Day	Year	3. Time of Death				
in al	Anne F. Miller	1					JUNI	_ / _		7100 A				
er	4a. Facility Name (If not institution	n, give street and num	nber)	4	b. City, Town, or	Location of Death		4c. C	ounty of Death					
	GOOD SAMARI	TAN HOS	SPITAL			IMORE								
	5. Social Security Number	6. Sex 1 ☐ M 2 💢 F	7. Age (<i>In yrs.</i> las 72		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	av. Year)	Cou	place (State or Fore ntry)				
	232-50-3953 Usual Residence of Decedent	T. A.	12	115.			Sept 2	4, 19.	34 Penn	sylvania				
	10a. State 10b. County		10c. City, 1	Town or Loca	tion		10d. Inside City							
ĕ	MD		Ва	ltimor	:e			1 ▼ Yes 2 N						
Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?						
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Funeral	11. Marital Status		edent Ever in U.S.	13. Wa	s Decedent of Hi	spanic Origin? (S	0. 14	. Race · Amen						
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Š	3 Widowed 4 Divorced	If Yes, Give Year or Da	ates:		1165 2 <u>M</u> 1N0	эр в спу.	3	ipecity:Whit	.e 					
Completed		nt's Education est grade completed)		(Give kir	nt's Usual Occupa nd of work done d	uring most of wor	16b. Kind	of Business/In	ndustry					
d l	Elementary/Secondary (0-12)	College (1-	-4or 5+)		NOT use retired,				141					
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Be	17. Father's Name (First, Middle, Otmar Jame					10. MOINER'S NAII	ie (Filst, Middi	e, Maidell S	umame)	u				
0			_	405 44-10-	4.11 (C11	No	/ O 4 1/	har Chara	Town Chair 7	- Codel				
- 1	19a. Informant's Name/Relations					nd Number or Ru				D (00 <i>0</i>)				
	Dennis L. Miller/spouse 5220 York Road #6N Baltimore MD 21212 20a Method of Disposition Date 20c. Location - City or Town, State													
	1 Burial 2 Cremation 3 Removal from State													
	4 □Donation 5 ☒ Other (Specify) in state													
	Baltimore, MD 21201													
_	23a. Part 1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between													
dical Examiner	Immediate a cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to inthe diate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):													
Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1☐Live bi	come of pregnanc inth 2 ☐ Fetal de ant at time of deal	eath 3 □E	ctopic pregnancy	,-		23d. Date of delivery Month Day Year						
ysiclan/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9☐Unkno		5 💆 6	Other (specify)									
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE **Physician** 2007 РМ J. **MYERS** 2:53 LINDA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE 824 CINNAMON RIDGE PLACE APT.B COCKEYSVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Months 59 06/24/1947 MO 489-52-7705 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 □ No Director BALTIMORE COCKEYSVILLE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21030 U.S.A. 824 CINNAMON RIDGE PLACE APT. Completed by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RECRUITER $MA_{-}L$ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LEVY **BESS** GITLIN WILLIAM 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 824 CINNAMON RIDGE PLACE APT. B 19a. Informant's Name/Relationship (Type. Print) RICHARD MYERS / HUSBAND COCKEYSVILLE MD 2103

Date 20c. Location - City or Town, State MD 21030 20b. Place of Disposition (Name of 20a. Method of Disposition HAR SINAI CONG. 1 X Burial 2 □ Cremation 3 □ Removal from State 06/24/2007 OWINGS MILLS, MD 4 ☐ Donation / 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signatur uneral/Service Lic 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of Approximate Interval Between Onset and Death aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and Due to (or as a consequence vi): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No Vital funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 2 ER/Outpatient 3 DOA Certification: To this Division or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Records, P.O. Box 68760 the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

Medical State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shawn Walter Robinson 31. Date filed (Month, Day, Year)

22 S.Greene ST Baltimore, MD. 21201 32. Registrar's Signature

MD

and manner stated.

29a. Certifier

(Check only

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

6-22-01

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM/200 per FH C870 8/16/07 WS
State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) JUNE 3 NUT Yeer **Physician** 2007 OWENS /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location 3. ...

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 3. ...) 4b. City, Town, or Location of Death Examiner WASHIN Correctional Institution Birthplece (State or Foreign Country) 5. Social Security Number UNV 6. Sex 7. Age (In yrs. last birthday) **Funeral** 3 Year) 1 M 2 F 9 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No **Funeral Director** HAGERS TOWN WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code SA 8601 746 -1000 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 14. Race - American Indian, or items 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify: BIAC H Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (Q-12) College (1-4or 5+) DRIVER TRUCH 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is marked o' HILDA ZENOBIA L.dE 19a. Informant's Name/Relationship (Type, Print) 5 15 4 15 R 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13313 LANE, F.+-WASh MD 2074
Date 20c. Location - City or Town, State WAShington QUEENS 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 1 Department of H Important: If its any injury or ot once. _Lincoln Cenetery 1 Burial 2 Cremation 3 Removal from State JUNE28.2007 BRENTWOOD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Phillip A. WEATHER FORD 21. Signature of Funeral Service Licensee Hully, All 2431 E. OliVER St BALTO MP 21213 23a. Part1. Ent if the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANC **Physician** /Medical Due to (or as a consequence of). Examiner EURAL E aquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9☐ Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) INFIRMARY ٩ 1⊠Yes 2 No After this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0663383 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGERSTUWN, MD 4 KESH MCIH 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) . ^{Day} 2007 June 21, **Physician** Puig 10:45 a^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5211 Benson Avenue n/a Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 117M 2□ F Hours Days 113-22-6634 75 1931 Director 8, New York Usual Residence of Decedent 10c. City. Town or Location f show 10a. State 10d, Inside City Limits s 1 and z shows ... f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 ☐ No Director MD Baltimore N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5211 Benson Avenue United States 21227 Funeral 12. Was Decedent Ever in U.S. Arged Forces?

1 Payes 2 D No
If Yes, Give 49-53
Year or Dates! 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. 1 Never Married 2 Married Specify: Puerto Rican altimore, Maryland 21215-0036 1X Yes 2□ No Specify <u></u> 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Fire Fighter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dr. Cav Puig Jennie Romero မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Puig/Wife 5211 Benson Avenue Baltimore Md 21227 20b. Place of Disposition (Name of centetry, crematory or other place)
MD Veteran Cemetery Crownsville

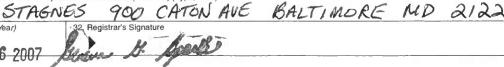
22c. Name and Address of Facility Ambrose Funeral Home, Inc. 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 → Burial 2 □ Cremation 3 □ Removal from State MD Donation 5 Other (Specify) 21. Signature of Funeral Service License 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CANCER METASTATIC **Physician** disease or condition resulting in death) 10 months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a detached for 1 Yes 2 No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed 2 No 1 TYes 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification properties of the funeral director, possible the funeral director, possible the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 □ Nursing Home 5 Residence 6 □Other (Specify)
Injury at 28d. Describe how injury occurred 2 No 1 🔲 Yes ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 3∏ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10+1

31. Date filed (Month, Day, Year)

EWCOLE



DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MICHAEL 20,2007 UNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAUTIMORE SELOURS 40 SPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) 5. Social Security Number unb 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**M 2□ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, th. Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimone MDDirector 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Federal (LSA Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Penningtan Nelson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, dity or Town, State, Zip Code) Michelle Pennington, /Daughter Federal Street Batto. MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 □Removal from State reenmount Chematoni 06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Funeral Services M06944 119-121 S. Stricker Balto MD 21223 23a. Part1. Enter the diseast, or comillio tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only be cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final theruseler Physician disease or condition resulting in death) /Medical (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔂 No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

32. Pegistrar's Signature

		_	For State Registrar	State of Ma	arylario ,		rtificate of I	4	F	eg. No.	2007	20522
	ysicia Medic		1. Decedent's Name (First, Middle, Last) Miriam Ba	tes P	ayne			7	2. Date of Dea Month June 2	Day	007 Year	3. Time of Death
	amin		4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town, or	Location of Death		4c.	County of Death)
			Gloria Friends Ass					Essex	T = = =		Baltim	
	eral ctor		23/ 22 8158	M 2 F	e (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 30	, Year)	15 Mar	pplace (State or Foreign intry) yland
aryland show	dat	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
Sa-f	otifie	Director	Maryland Baltimore		Ess	sex						1 ☐ Yes 2 ☐ No
with th	pe no		10e. Street and Number	- Ͻτι			10f. Zip Code 212	221			zen of What Cou SA	untry?
eath ns 23	must	Funeral	1120 Tace Drive Ap	2. Was Decedent E	ever in U.S.	13.			ecify Yes or No-		14. Race - Amer	ican Indian,
1215-0036 within 72 hours after death with the Maryland ene.	or other traumatic event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:	lo		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	an, Mexican, Puerto Specify:	Rićan, etc.)		Black, White	_{v, etc.} White
5-06	dical	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	1 1	6a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	ting	16b. Ki	nd of Business/I	ndustry
2121 of within giene.	the Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		etary	1)		Bal	timroe (County Schoo
Maryland 21215-0036 d 2 should be filed within 72 hours aff fill mand Mental Hyglends 17 is marked other than "natural"; or	ic event	To Be (17. Father's Name (First, Middle, Last)				UNK.	18. Mother's Nam	e (First, Middle,	Maiden	Surname)	UNK.
Tarylan 2 should be and Menta	raumat		19a. Informant's Name/Relationship (Тур	e. Print)	Į.		ng Address (Street					•
e, M 1 and 2 Health em 27 i	her tr		Gloria Beseris (pe	rsonal Re			ack River		ad Essex			
More Pages 1	or ot		20a. Method of Disposition 1 Marial 2 □ Cremation 3 □ Records 1 □ Records 2 □ Records 3	emoval from State	cem	eterv. cirei	natory or other place f Faith (ce)			imore Co	ounty, Md.
Baltimore, permit. Pages 1 ar Department of Hea	any injury once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Euneral Service/License	e)	(2. Name and Addres				uneral 1	
m ege	an		ha 3				07 Old Ea	astern Av	enue Es	sex		
Physic	cian		Imme Late Cause (Final diseas or condition Conge	cations that caused e cause on each lin stive Hea				ig, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death 10 Years
/Med Exam			resulting in death)	Due to (or as a			Conding	-aulan Di	20020			10 Years
68760, tificate be executed on physician and	as the burial-transit	ш	Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequen	ice of):	Cardiovas	scular Di	sease			10 Teals
687 ificate	as the	edical	d							2.22.11		
	be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	3c. If yes, outcome p 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)	/			23d. Date of deli Month	very Day Year
S, P es that	be deta	by Pt	Part II. Other significant conditions con		ut not resultir	ng in the u	nderlying cause giv	en in Part I.				the cause of death?
ord requir	should	ted	Alzheimers Diseas	<u>e</u>					1 1 1	es 2[_No 3L x Pro	obably 4 ∏Unknown
Division or Vital Records, or Attending Physician: The law requires that dier death. Director: After this certificate has been signed.	page 2 sh	Completed by									death?	topsy findings available completion of cause of 2 No
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or \	al dire	ို	1 les 22 140	ospital: 1 ☐ Inpatie			it 3□ DOA Oth	er: 4 Nursing Ho				assisted ify) living
Division or Vital Rec To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has	the funera	Certification:	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injur (Month, Day	Year)	3b. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	ow injur	y occurred	
DIVI tal or Att	ed in by	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of inju building, etc	iry - At home c. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tow	treet an n, State	d Number or Ru)	ral Route Number,
te Hospit 124 hour e Funera	oletely fill	Medical (29a. Certifier (Check only one) 12 Certifying Phys 2 Medical Examir	ician: To the best oner: On the basis of	examination	edge, deat and/or in	h occurred at the tir vestigation, in my o	me, date and place opinion, death occur	and due to the cred at the time,	ause(s)	and manner as d place, and due	stated. to the cause(s)
To th To th	сошр	Me	29b. Signature and title of certainer	// 1			29c. Licens	e number		29d. Dat	te signed (Month	n, Day, Year)
	1		· / //	Janha			D183	26			June 25	,2007
-	5		30. Name and address of person who co Naeem Gauhar MD					n D13 =		4		
	Sta	e	31. Date filed (Month Pay, Year)	Essex Med 32. Registra	ar's Signatur	ente	r Laster	n Blvd Es	sex Md 2	:122		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2007 12:47a June 2 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harmony Hall Assisted Living Columbia Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10 03 20 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1□M 2√2F Director 86 218-12-0220 death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits Director XXYes 2 No Baltimore NA MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or U.S.A. 21215 4111 Fernhill Ave Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or ite any injury or other traumatic event, the Medical Examines 1 Yes Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Black 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Adm Case Worker 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maggie Hunter Floyd Flacks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 19a. Informant's Name/Relationship (Type. Print) 8625 Willow Run Road, Windsor Mill, Md Wendy Robinson-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet 6/27/07 Owings Mills, Md 21. Signature of Funeral Service Licent 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part1 Enter the disease, or complications that caused the feath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has to irector, page 2 s autopsy performed? 2 D(No the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this IV:na 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After (1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be n 24 hours after der he Funeral Directo pletely filled in by th 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical To the Hosp within 24 hor To the Fune completely fi and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie une

State Registrar 30. Name and address of person who com

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31. Date filed (Month, Day, Year)

oleted cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 06 $2\overset{\text{Day}}{1}$ **Physician** 2007 Charlotte Ann Price 1:42 рΜ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10806 Wheeler Dr. Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 💢 F 020-32-1835 63 Director 8-9-1943 Massachusetts Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20901 10806 Wheeler Dr. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ William Beard Price Elizabeth McCree 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Zambia M. Davis/daughter 10806 Wheeler Dr. Silver Spring, MD 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 6-26-2007 Beltsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 01358 Rapp Funeral & Crem.Svc.933 Gist Av. SilverSpring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 6 months Lung Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical the IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 5 ☐ Other (specify) 4□Pregnant at time of death 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

D53590

6/22/2007

PHYSICIA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sydney Ny 624 N. Broadway #609 Baltimore, MD 21205
31. Date filed (Month, Day, Year) 22. Registrar's Signature

10 miles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month O **Physician** Ross, 8 /Medical 4b. City, Town or Location of Death ounty of Death Examiner If Under 1 Year 8. Date of Birth (Month, Day, 05 25 Birthplace Country) **Funeral** Year) Months Days 220.34 1940 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at Baltimore 1XYes 2 No Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Road 21206 5909 Kegis Funeral [US4 1 and 2 should be filed within 72 hours after death Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Black Specify. þ 3 Widowed 4 Divorced Completed Injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Property Management Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If them 27 is marked other the any Injury or other treasures. Maintenance Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora Glover ROSS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Regis Road Balto. Ross 5909 JOAnne 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 Removal from State 29/07 Dulaney Valley
2. Name and Add so Imonium, 21. Signature of Funeral Service Licensee 23a. Part . Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) tastases **Physician** alcinoma w /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 29a. Certifier 🛮 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06/5 00000

State Registrar

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6 2007

31. Date filed (Mont

9000 Franklin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2159P M Virginia M. Rodriquez 21 6 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAITIMORE Rosedale FRANKlin SqUARE HOSDILA If Under 1 Year If Under 24 Hrs. 5. Social Security Number In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 78 Months Days Hours 1 □ M 2 🛛 F 219-22-7259 02-01-1929 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Perry Hall the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 8 Hobb Ct 21128 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status VIRginia Rodaiaue Baltimore, Maryland 21215-0036 th and Mental Hygiene. 7 is marked other than "natural", or item traumatic event, the <u>Medical Examiner</u> i Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fiancial Associate State of Maryland 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Schlegel Josephine Cichowicz 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; if Item 27 is any Injury or other traulonce. 7500 Days Woods Ct Kingsville, Kimberly Geisler (Daughter) MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 06-25-2007 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Timonium, Maryland 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd Baltimore, MD 21236 21. Signature of Funeral Service L 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Therosci /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 2 No 1∐ Yes funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA Certification: To 1 Yes 2 No 1 Inpatient this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 🗖 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who complete

DAVID 31. Date filed (Month, Day, Yeàr)

HA

2007

QUARE DR. BAITIMORE Md

ause of death (Item 23a) (Type, Print)

07-04769 Moeen Raja

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Time of Deat Physician/ Month Day June 22, 2007 Medical Examiner 2358 hrs MOEEN SADIQ RAJA 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Ellicott City Howard 3147 West Springs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** Months Days Hours Director 08-29-1985 21 XX_{M} Country) 220-08-8118 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 'n 10h County 10a State MD HOWARD ELLICOTT Yes 2 X No 28a-f show must be notified at once. death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3344 HOLLOW COURT 21040 USA items 23a or Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 Married Yes Pages I and 2 should be filted within 72 hours after onent of Health and Moutal Hygiene.
ant: If item 27 is marked other than "natural", o Yes 2 X No specify: If Yes, Give Year Specify: ASIAN 3 Widowed Divorced <u>م</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed College (1-4 or 5+) Elementary/Secondary (0-12) utal Hygiene. the Medical 21215-0036 3 yrs 12th NA NΙΑ 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SADIO SUBAH RAJA MUNAZZA SADIO RAJA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ø E ZAFAR FAROOQ -UNCLE 440 DOE MEADOW DR. OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State partment o 06-24-2007 KING MEMORIAL PK. RANDALLSTOWN, Donation 5 Other Specify: 5 22. Name and Address of Facility of Funeral Service License 4300 WABASH AVE. MARCH FUNERAL HOME WEST MD 21215 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and ure List ontwone cause on each line. Medical Death a, Gunshot Wounds (2) to Back and Arm Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death Month 2 past 12 months? Pregnant at time of death Other (Specify) has been signed by the att 2 should be detached for 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available certificate has been prior to completion of cause of autopsy death? performed? page ✓ Yes 2 Yes 1 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene this 1 ✓ Yes No After the 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Subject shot FOUND: 1 Natural 1 Yes 2 ✔ No Pending Jun 22, 2007 2347 hrs 2 Investigation Accident

Division of Vital Records, P.O.

Hospital or Attending Physician: death. Director: d in by the f To the I within 2 To the I

3 Could not be Suicide determined 4 V Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

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2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year)

June 23, 2007

28f. Location (Street and Number or Rural Route Number, City

or Town, State) 3147 West Springs, Ellicott City, Md.

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD

31. Date filed (Month, Day, Year) State Registra

32 Registrar's Signature

(Specify) Local Street

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 09 2007 Rosenbrock dwin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Manyland Medical Center Baltimove If Under 1 Year If Under 24 Hrs. Social Security Number
 213-52-4917 7. Age (In yrs. last birthday) 58 Yrs. Date of Birth (Month, Day, Birthplace (State or Foreign **Funeral** Hours Year) Days Months Min. 1 XM 2 ☐ F 8/12/48 MD Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State show the Medical Examiner must be notified at 1X Yes 2 □ No N/A Baltimore City Director MD 23a or 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 USA 842 Mangold Street Funeral 14. Race · American Indian, itеms 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or ite any Injury or other traumatic event, the Medical Examine and. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edwin H. Rosenbrock Jane F. Nelson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 926 Church Street, Baltimore MD 21225 Darlene N. Brown / Sister 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Bayview Crematory 1 ☐ Burial 2 X Cremation 6/25/2007 3 ☐Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Victor P. Doda, Jr22. Name and Address of Facility 21. Signature of Funeral Servi Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tupoxia /Medical to (or as a consequence of): **Examiner** Emphysema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the burla Physician/Medical 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this after death.

I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 1 🗷 certifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

Keena Shah 31. Date filed (Month, Day, Year)

JUN 2 6

Greene Street, Bathmore, MD 21201

Kesident Physician

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

South

29c. License number

AU4176435517463

29d. Date signed (Month, Day, Year)

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	5	State of Ma	arylan		artment rtificate				-	giene Reg. No.		20523
			Decedent's Name (First, M	iddle, Last)			-					2. Date of De	ath Day	y Year	3. Time of Death
	Physicia /Medic		Ines Sanchez									JUN	20	2007	
	Examin	er	4a. Facility Name (If not institu ST · A G ∼		eet and number) +) cs P i	TAL		4b. City,		Location of		2 6	4c.	County of Death	1
	Funeral	.A.	5. Social Security Number	6. Sex			ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	th (9. Birtl	nplace (State or Foreign untry)
	Funeral Director		451 - 58 - 2125	1 √ M	1 2□ F	77	Yrs.	Months	Days	Hours	Min.	Jan. 2		930 Texa	nntry)
	pu »		Usual Residence of Decedent 10a. State 10b. Cou			10c. City	, Town or Lo	ocation							10d. Inside City Limits
	faryla shov	ō		imore			downe								1 ∐Yes 2 x No
	the N	rect	10e. Street and Number					10f. Zip	Code				10g. Cit	izen of What Co	untry?
	h with 23a or st be	Funeral Director	141 Fifth Aver	nue				2122	27				U.S	.A.	
	ems ser mu	ner	11. Maritai Status	12	. Was Decedent Armed Forces?		S. 13.	Was Deced	ent of Hi ify Cuba	ispanic Or in, Mexica	igin? (Spe	ecity Yes or No Rican, etc.))-	14. Race - Amer Black, White	
36	s after	by Fu	1 ☐ Never Married 2 🔀 I		1 ☐ Yes 2 ☐X If Yes, Give Year or Dates:	No		1 ☑ Yes 2	2□ No	Specify:				Specify: Mex	rican
21215-0036	be filed within 72 hours after death with the Maryland tital Hygiene. od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at event,	ed b	15. Dece	dent's Educa	tion		16a. Dece	dent's Usua	l Occup	ation			16b. K	(ind of Business/	Industry
215	hin 72 e. in "na Medic	Completed	(Specify only his Elementary/Secondary (0-1		completed) College (1-4or t	5+)	(Give life.	dent's Usua kind of wor DO NOT us	k done d e retired	during mos l)	st of work	ing			
21,	filed withi Hygiene. ther than int, the M	Com	8			,	Labor	er				/FI		structio	on
Maryland	be file od oth even	Be	17. Father's Name (First, Mid Camilo Sanche									(First, Middle		i Surname)	
ryla	hould d Mer marke	ဍ	19a, Informant's Name/Relat	-	Print)		19b. Maili	na Address				Ordan		or Town, State, Z	Zip Code)
<u>≅</u>	nd 2 s ulth an 27 is i		Hilario Sanche				i	•				owne M	-		. ,
Ē,	s 1 ar		20a. Method of Disposition		15 01-1-	20b. P	lace of Dispo emetery, cre	osition (Nan	ne of ther plac	(e)		Date		ocation - City or	
<u>n</u>	Page nent c		1 □ Burial 2 🖺 Cremat 4 □ Donation 5 □ Othe		noval from State	Wes	st Aru	ndel (Crem	atory	7 6-2	1-2007	0de	nton, Ma	aryland
Baltimore,	permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumatic event, the once.		21. Signa up of Funeral	vice Licens	11.0	Va	A	2. Name an	d Addres	ss of Facil nera	L Hom	e of L	ansd	owne	
	© ∪ = # 9	- 0	23a. Part1. Enter the diseas		W/ Co	d the death	2	719 Ha	ammo	<u>nds I</u>	erry	Rd. L	ansd	owne MD	21227 Approximate
			shock, or heart failure.	List only one	cause on each li	ne.									Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a.	Due to (or as			JUL	40	NAH	₹Ÿ	EDE	MA		8 DAYS
	Examiner				240 10 (0. 40									-	
	D #	ner	Sequentially list conditions. Due to (or as a consequence of): cause. Enter Underlying.												
	icate be executed physician and s the burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
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E S	ficate physics the	edical		d.											
ZX	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnan	t 230	. If yes, outcome			□Ectopic p	0.000000					23d. Date of del	
B	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		1□Live birth 4□Pregnant a 9□Unknown			Other (sp		/				Month	Day Year
9.0 0.0	res that the de signed by the a be detached	Phys	9 ☐ Unknown Part II. Other significant coi			ud not roo	ulting in the	indodvina o	nuco div	on in Dart	1	23e Did	tobacco	use contribute to	the cause of death?
में दे	The law requires that the death certifite has been signed by the attending bage 2 should be detached for use as	ρ			REN				ause giv	eninran	1.				robably 4 Unknown
C M E	w require been signated should b	Completed	DIADETT		4ELL			<u> </u>				24a. Wa	s an	24h Were at	utopsy findings available
A. P. P.	he lav e has ige 2 ;	mpl	JUDED	TEN.		((~						auto	opsy formed?	prior to death?	completion of cause of
Z <u>F</u>		Be Co	25. Was case referred to me		SION					26. Plac	e of Deat	1 Yes h (Check only	2 No one)	o 1 ☐Yes	2 2 110
<>	Physician: r this certifica ral director, I	To B	examiner? 1 ☐ Yes 2 ☑ No	Но	spital: 1 Inpati	ent 2	ER/Outpatie	ent 3 🗆 DC	Oth	ier: 4□N	lursing Ho	me 5⊟Res	sidence	6 □Other (Spe	cify)
000	ng Pt		27. Manner of Death 1 Natural 5 □ Pe	endina	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time o Injury		8c. Injui Wor			28d. Describe	how inju	ury occurred	
sio	ttending death. stor: After	catio	2 Accident in	vestigation ould not be	28e. Place of in	ium. At h	omo farm si	M I		Yes 2	No	28f Location	/Straat a	and Number or P	ural Route Number,
Division	after o	Certification:	4 ☐ Homicide de	etermined	building, e	tc. (Specif	y)	ireet, lactor	, onice			City or To			uiai i iouto ivuiniboi,
1000	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 ☑ Cer	tifying Physi	cian: To the best	of my kno	owledge, dea	th occurred	at the ti	me, date a	and place	and due to th	e cause(s) and manner a	s stated.
	the Ho hin 24 h the Fu npletely	Medical	(Check only 2 Med one)	dical Examine	er: On the basis and manner s	of examina tated.	ation and/or i	nvestigation	i, in my	opinion, de	eath occu	rred at the time			e to the cause(s)
	Vithi To th	Σ	29b. Signature and title of ce	ertifier	relias	9		29	c. Licens	e number	01	~ 1.	29d. D	ate signed (Mon	th, Day, Year)
	15		Karpo	~ · · · · · · · · · · · · · · · · · · ·	relas	ICAL	OFFI	CER	V	005	145	>4	00	710 20	, 200
	4		30. Name and address of pe	rson who con	pleted cause of RAKA-	death (Iter	n 23a) (Type ?) [*)	Print)	L	STA	FF	OFFIC	E.	STA	GNES HOSPITAL
	Sta	te	31. Date filed (Month, Day,			trar's Sign	ature	-07		_	-	. , , .			HOSPITAL
	Registr		HIN 9	6 2007	Berein	w L	ture								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2007 June **Physician** 23, Eugene Edward Smith 10:48 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Severii | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. | 14, 1940 8020 Fair Breeze Drive Anne Arundel 5. Social Security Number 6. Sex. 1 1 4 M 2 □ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Mary Land 220-36-2112 66 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2X No Director MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8020 Fair Breeze Drive 21144 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 No 19. If Yes, Give Year or Dates: 190 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black White etc. 1957-1 Never Married 2 Married 1 ☐ Yes 2 📉 No White Specify Specify: ģ 1963 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Staircase Elementary/Secondary (0-12) College (1-4or 5+) Field Rep. Specialist Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Frank Smith Mary K. McMenamen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen P. Smith - Wife 8020 Fair Breeze Drive, Severn, MD 21144 20b. Place of Disposition (Name of West Architecture) Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition TD Burial 2 XCremation 3 ☐ Removal from State 6-26-2007 Odenton, MD 4 ☐ Conation 5 ☐ Other (Specify) 21. Signature of Euneral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final C14 come disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ဥ 1 Inpatient 27. Manuar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician attending p the signed by has this certificate

Funeral

Director

28a-f show

or items 23a or 28a-f show

natural

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

permit. Pages 1 and 2 should be i Department of Health and Mental I Important; If Item 27 Is marked o

0

injury o

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After to ompletely filled in by the funeral

State

29b. Signature and title of certifier

6 Could not be determined

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

JUM = 26, 2007 (was Hashway

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11/26 1021 column of

egistrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

3 ☐ Suicide

29a. Certifier

Medical

4 ☐ Homicide

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

032275

29d. Date signed (Month, Day, Year)

JUNE 24, 2007

Division or Vital Records, P.O. Box 68760,

Examiner The law requires that the death certificate be executed and attending phase as t signed by the a certificate has this After To the Hospital or Attending neral Director; / hours after 24 hours a completely the 0

Medical State

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

DR. DAVID DUNN - 615 W. MACPHAIL ROAD - BEL AIR, MD 21014 32 Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		rtificate of l			Reg. No.	7 -7	7 7 7 7 7	
4		,	Decedent's Name (First, Middle, L.	ast)				Date of Dea Month	ith Day	Year	3. Time of Death	
	Physicia /Medic		Leamond	L.		Suggs		June		2007	5:30a M	
	Examin		4a. Facility Name (If not institution, g.	ive street and number)			Location of Death		4c. Cour	ity of Death		
			Future Care Nu	rsing Home	e		imore If Under 24 Hrs.	8, Date of Birth		0.5:11		
	Funeral Director		5. Social Security Number 6. 240-32-8534 Usual Residence of Decedent	AFIM OFF	n yrs. last birthday) 7 Yrs.	Months Days	Hours Min.	08 1	, Year)	9. Bittip Cour	place (State or Foreign htry)	
	fand ow it		10a. State 10b. County	10	0c. City, Town or Lo	ocation				1	l0d. Inside City Limits	
	d within 72 hours after death with the Maryland sjene. Jiene. 't fran "natural", or Items 23a or 28a-f show then "natural", or Items 21a on 28a-f show the Medical Examiner must be notified at		MD NA		Baltim	ore					1 X Yes 2 □ No	
		Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Cou	ntry?	
			3918 Liberty H	eights Ave	AptB-1	2.	1207		U.	S.A.		
		Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14, R	ace - Americ lack, White,		
21215-0036		þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 🏖 No	Specify:		Spec	cify: Bl	ack	
5		To Be Completed	15. Decedent's (Specify only highest g	Education rade completed)	i (Give	dent's Usual Occup	during most of work	ing [16b. Kind of	Business/In	dustry	
121			Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired aborer	1)		Den	Clea	nor	
	filed Hygi ther nt, t		12th grade	na na	<u> </u>	aborer	18. Mother's Name	e (First, Middle,			ner	
Maryland	be d o		Nora Murahy									
<u>2</u>	2 should by and Menta Is marked aumatic ev		James Suggs 19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Street	and Number or Rur	al Route Numbe	er, City or Tow	n, State, Zip	² 21207	
	r t 2		Carmen Tuitt-F	riend	3918	Libert	v Height	s Ave	Apt I	3-1.	Balto, Md	
Je,	s 1 a of Hea Item		20a. Method of Disposition		20b. Place of Dispo	osition (Name of matory or other place	ce)	Date	20c. Location			
altimore,	Pages nent of I ant: If Ite ary or o		1 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	☐ Removal from State		n Fores		/28/07	Owin	nas M	ills, Md	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lio	/\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	2	Name and Addre	H West				21215	
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	/Medical		disease or condition resulting in death) a. a. a. Due to (or as a consequence of):									
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	tificate be executed g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):									
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	ding page as	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcome pf	pregnancy			13-12-12-1	0011	. <u>!</u>		
P.O. Box	The law requires that the death certifi te has been signed by the attending age 2 should be detached for use as		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Live blirth 2 □ Fetal death 3 □ Ectopic pregnancy in the past 12 months? 4 □ Pregnant at time of death 5 □ Other (specify)							Date of deliv Month	Day Year	
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Vital Records,	n requires been sign should be		Chronic obstructive Pulmonary disease						1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown			
ပ္တ	aw res		A-F.'D						24a. Was an 24b. Were autopsy findings available			
Ä	The I	E	autopsy / prior to completi performed? death? 1 Yes 2 No 1 Yes 2						mpletion of cause of 2□ No			
ital			25. Was case referred to medical examiner? 1									
or V	Physician: this certific ral director,									fy)		
0 _	ng ffer		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	of 28c. Injur Wor	y at k?	28d. Describe h	now injury occ	urred		
Division	Hospital or Atten 4 hours after deatl Funeral Director: ely filled in by the	atic	2 ☐ Accident investigati	ho !	1		Yes 2 □ No					
		Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num City or Town, State)							al Route Number,		
		Medical C									to the cause(s)	
	To the within 2 To the complet	Ž	29b. Signature and title of contifier	1		29c. Licens			29d. Date sig			
			MD DOO 63534 Jun, 22, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mandana Shahbazi 25 main street ReisTestown MD									
1	sta			iahbazi	th (Item 23a) (Type, 25 n	Print)	eet Re	isTesto	wn.	MO		
State 31. Date filed (Month, Day, Year) Registrar JUN 2 6 2007				2. Registrar's	Signature							

7-04767	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene								
Cornell L. Stampe		- For State			nt of Healt te <i>of Deatl</i>			201	17 2053
Physician		Registrar 1. Decedent's Name (First, Middle,La		oci tinodi	.c or bean		2. Date of Deat	g. No.	3. Time of Death
Medical Examine	-	Cornell	Levoid	ce	Sta	amper	Month June 22, 2	Day Year 007	2230 hrs
	1	4a. Facility Name (if not institution, gi	ve street and number)		1	own, or Location of Dea	ath	4c. County of Dea	th
	Ę	Sinai Hospital			Baltim				
Funeral		5. Social Security Number 6. S		yrs. last birtho	lay) If Unde	er 1 Year If Under 24F s Days Hours M	lin.	h(MM/DD/YYYY) 9. B Fore	ign
Director			M 2 F 19)	Yrs.		10 2	3 87 ^c	ountry) MD
any	-	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or	Location		*		10d. Inside City Limits
* .		MD NA	1	Balti	imore				1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zip	Code	10	g. Citizen of What Co	untry?
the the		2021 Ruxton A	ve			21216		U.S.A.	
ms 23	era 	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.		nt of Hispanic Origin? (y Cuban, Mexican, Pue		14. Race - Ame White, etc.	rican Indian, Black,
r death	Funeral	1X Never Married 2 Marrie	1 Yes 2 X	No			,		Black
rs afte	ᇍ	3 Widowed 4 Divorce 15. Decedent's Education (Specify of	d If Yes, Give Year or Dates:	rd) 16a Dr		No specify: Occupation (Give kind of	of work done	Specify: 16b. Kind of Business	
2 hour	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			king life. DO NOT use		Johns Ho	
5-0036 ted within 72 hou lygiene. other than "nat	힏	12th grade	lyr		Clerk	2		Hospital	
		17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname)							
21215-0036 Build be filed within 7 Mental Hygiene. marked other than c event, the Medica	8	Cornell Eugen	e Eldridge	1.0			one Star		7.0.4.
U å 5 5 € [٩	19a. Informant's Name/Relationship (160		(Street and Number of	-		
≥ 9g g g g	ŀ	La Shone Stam 20a. Method of Disposition	<u>ser-Motner</u>	20b. Place of	Disposition (Nar		Date	20c. Location - City	21216 or Town, State
nor6 iges l nt of F t: If i		1 X Burial 2 Cremation 3	T.		y or other place)	al Park 6	/28/07	Randalls	town.Md
E ~ 8 E F	+	4 A Donation 5 Other Specification 21. Sign ture of Funeral Service Lips	y.			Address of Facility F/H West	, 20, 01	manaazz	
Balti permit. Departn Import		Lumi !	Kek		14300 V	Vabash Av	e, Balt	imore, Mo	21215
Physician	1	23a. Part I. Enter the disease, or com	plications that caused the c	leath. Do not	enter the mode	of dying, such as cardia	c or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
Medical Examiner	ı	Immediate Cause (Final disease	Multiple Injuries						Death
	-	or condition resulting in death)	Due to (or as a consequer	nce of):					
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tecuted and transit	<u>ا</u> يّ	events resulting in death) Last	i.	1100 01).					
6 H H H	턀	UNPENDED	AMENDED						
Box 68760, e death certificate be except attending physician ed for use as the burial.	Physician/Medi	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of delive	•
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30x 6 death cer te attendi	ysic	1 Yes 2 No 9 Unknow	- Land	ordeau 5	Other (Spe	cify)		ì	
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ords, w requires been should	Completed						24a. Was autor	osy prior to	autopsy findings available completion of cause of
Reco	E						perfo 1 ✓ Yes	rmed? death′ 2 No 1 ✔	
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Physic al dire	2	1 Yes 2 No		2 V ER/Out	<u> </u>		rsing Home 5	Residence 6 Oth	ner:
n of ding Ph. h. After t		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year) Jun 22, 2007	2125		28c. Injury at Work? 1 Yes 2 ✓ No		auto fixed object	collision
Sio	Cati	2 Accident Investiga	28e Place of Injury	- At home, far	m. street, factory	-110-010-07	28f. Location (Street and Number or	Rural Route Number, City
Div	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street or Town, State) 4 Homicide determined (Specify) Local Street							
bou hou		29a. Certifier Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
To the within 2 To the complet	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
F S F S	ž	29b. Signature and title of certifier				29c. License number		29d. Date signed (Month, Day, Year)	
Mayour me Unel					O.C.M.E. June 23, 2007				
30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201									
		Margarita Korell MD. A 31. Date filed (Month, Day, Year)	32 Registrar's S		i i i e e i ii o i				
Sta Registr		11.141	107 Magrae	B. A	houses				

Registrar DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 03:01 June 24 2007 Sterrette Marie /Medical Anita 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Towson Gilchrist Nursing Home If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 👿 F Yrs. 74 32 219-28-3926 09 14 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Y☐Yes 2 No Baltimore Director NA MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21216 3308 North Hilton Street #102 Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 🌠 ☐ No Black Specify Specify: 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Anita Painting 12th grade House Printing Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Blair Weems Hackett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 4100 Underwood Road, Baltimore, Md 21 ce of Disposition (Name of Date 20c. Location - City or Town, State Devereaux Sterrette-Son 20a. Method of Disposition 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory Inc 6/25/07 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Sig tul of Funeral Service Licensee 22. Name and Address of Facility March F/H West 21215 Vame nom DSan 4300 Wabash Ave, Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CHF weeks /Medical Due to (or as a consequence of): Examiner CAO Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 | Yes 2 | No 3 Probably 4 | Unknown certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 45 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed n 24 hours after death.

e Funeral Director; Af

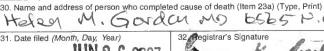
within 2 State

31. Date filed (Month, Day, Year) JUN 2 6

29b. Signature and title of pertin

29a. Certifier (Check only one)

Helen



MD

and manner stated.

2007

6565 P. Charles St, Baltman MD 21201

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

00051926

29d. Date signed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	State of Marylan 1 - State Amend #10b, perFH, g868, 6/26/07	nd / Department of Health and Me $^{ m TT}$ Certificate of Death	ntal Hygiene		
	Physici /Medic	an	1. Decedent's Name (First, Middle, Last) EVEL YM ROBERTA	ShERMAN	Date of Death Month Da	3. Time of Death	
	Examin	er	4a. Facility Name (If not institution, give street and number) 1436 Milton Avenue 5. Social Security Number 6. Sex 7. Age (In yrs	4b. City, Town, or Location of Death BALTIMORE last birthday) Iff Under 1 Year Iff Under 24 Hrs. 8		BUHMURE C: HY 9. Birthplace (State or Foreign	
d)	Funeral Director		21.7 · 34 · 0842 1□ M 210 = 7 9 Usual Residence of Decedent	Yrs.	Date of Birth (Month, Day, Year)	28 GEDIGIA	
	he Marylar 28e-f ehow ciffied at	Director	MD Beltimore B	BOST HIMORE City 109. Zip Code	10g Gir	10d. Inside City Limits 1	
	death with t ms 23a or 2 must be n	Funeral Dir	10e. Street and Number 1436 Milton Avenue 11. Marital Status 12. Was Decedent Ever in 1	U.S. 13. Was Decedent of Hispanic Origin? (Speci	fy Yes or No-	USA 14. Race - American Indian,	
5-0036	72 hours after death with the Maryland neturel; or Items 23s or 28e-f ehow dical Examiner must be notified at	by	Amed Forces? 1 Never Married 2 Married 1 Yes 2 PNo If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Ri		Black, White, etc. Specify: Black	
21215-(within ene. then	Completed	15. Dacedent's Education (Specify only highest grade completed) Etementary/Secondary (0-12) Cottege (1-4or 5+)	16a. Decedent's Usual Occupation Work and of work done during most of working life. DO NOT use retired) Environmental		ind of Business/Industry 140. Ci4u (School Sustan)	
and	should be filed nd Mental Hygid marked other umatic event, III	To Be C	17. Father's Name (First, Middle, Last) ONORA	STEVENS Edna	First, Middle, Maiden TOA W	Sumame) /	
e, Maryl	1 and 2 sho Health and 1 em 27 is mu ther trauma		19a, Informant's Name/Relationship (Type, Print) One Sharmon 20a. Method of Disposition 20b.	19b. Mailing Address (Street and Number or Rural I	ue Bette	or Town, State, Zip Code)	
Baltimore	Page nent c ant: if ury or		1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	cemetery, crematory or other place) LOW HUS MEM PK 22. Name and Address of Facility A A	of BA	140 MD	
B	permit. Departrimporte importe eny inji		23a. Part 1. Enter the disease, or complications that caused the dec shock, or heart failure. List only one cause on each line.	Phillip A. Wentherford ath. Do not enter the mode of dying, such as cardiac or	Funeral SV respiratory arrest,	C. 2431 E. Oliver St. Approximate Interval Between	
7.5	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Acute Due to (or as a conse	Myelgenous Le	nken:	Onset and Death 4 Months	
8760,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerei Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dicai Examiner	Sacuration in the conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consection of the condition of the c				
P.O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 (UM) 0 9 ☐ Unknown 23c. If yes, outcome of pregnant at time of 9☐ Unknown	tal death 3 □Ectopic pregnancy		23d. Date of delivery Month Day Year	
		ρ	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death? ☐ No 3 ☐ Probably 4 ☐Unknown	
of Vital Records,		Completed			24a. Was an autopsy performed? 1 Yes 2 XNo	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No	
Vita		To Be	25. Was case referred to medical examiner? 1 Yes	26. Place of Death ☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Hom.	Check only one)	6 □Other (Specify)	
o uc		lon: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year)		28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Division		Certification;	2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, street, factory, office			
		Medical C	(Check only 2 Medical Examiner: On the basis of examinand manner stated.	nowledge, death occurred at the time, date and place, an nation and/or investigation, in my opinion, death occurred	d at the time, date an	d place, and due to the cause(s)	
	with Com	2	29b. Signature and title of certifie	29c. License number	1 July	ate signed (Month, Day, Year)	
	0 1		30. Name and address of person who completed cause of death (It	1208-6 Lund Mus	deldhar	e mo 21255	
	Sta Regist		31. Date filed (Month, Day, Year) JUN 2 6 2007 32. Registrar's Signary	nature Apartic			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Day 2007 **Physician** 6:00AM ma /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cedar atonsvil Baltimore ircle Date of Birth (Month, Day) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8 1□M 2**X**F **Funeral** Months Hours Min Days Yrs. Director Usual Residence of Decedent 10c. City, Town or Location la or 28a-f show t be notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore MID Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 2 and Injury or other traumatic event, the Medical Examiner must be no once. 2008 21228 ircle Drive by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify. 3 ☐ Widowed 4 ☐ Divorced Blach Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meinager Social Security 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William. ဂ Minnie Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2008 Cedar C Marion Scabrocks/Husband ircle Dr. Catansville MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State Forest 06.28.2017 (Wings Mills, MD) 22. Name and Address of Facility Vougan C. Greene Tuneral Service 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter de disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 728 Liberty And Mandallstam MD 21133 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vonsmall /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to in manage cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Examiner The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Day Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a detached f 9□Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 ☐ Nursing Home 5 💢 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death. the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0051

Registrar
DHMH 17 Rev 1/2001

State

0

1605 Orleans Street Bultimore Maryland 21231-1000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Julie R. Brahmer

Day, Year) 2 6 2

2007

31. Date filed (Month,

		1	For State Registrar		State of M	faryland		artment of H		d Mental Hy	giene 007	20537
	Physicia /Medic	an al	1. Decedent's Name (Fir KATHAR 4a. Fecility Name (If not	INE		SOM	ME	4b. City, Town, or	Location of D	2. Date of De Month	Day Yeer 4c. County of Dee	3. Time of Death 7 10:45P M
	Examin Funeral	er	4a. Fecility Name (if not 1 3 8 0 / 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	PIZ RO	· , A P	T. H	ast birthday)	If Under 1 Year Months Days	15 V/ If Under 24	LLE	BALTI	MORE State or Foreign
	Director		Usuel Residence of Dec		M 228 F	10c. City	Yrs.					10d. Inside City Limits
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	h with th	ai Dire	10e. Street and Number 13801 York	Rd. Ap	t. H-8			10f. Zip Code 21030			10g. Citizen of What Co USA	ountry?
036	be filed within 72 hours after death with the Maryland ital hygiene. Id other than "natural", or Itams 23s or 28s-f show event, Ira Medical Examinar munitor notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4 ☐	2 Married	12. Was Deceder Armed Forces 1 ☐ Yes 2 2 If Yes, Give Year or Dates	s? \$No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 2 No	ispanic Origin in, Mexican, F Specify:	? (Specify Yes or N Puerto Rican, etc.)	o- 14. Race - Am- Black, Whi Specify: Wh:	te, etc.
21215-0036	within 72 ho lene. • then "naturalls	Completed	15. (Specify o	Decedent's Education of the Education of	cation com <i>pleted)</i> College (1-4o	r <u>\$</u> +>	(Give	dent's Usual Occupi kind of work done of DO NOT use retired archer	durina most o	f working	16b. Kind of Business Public Hea	Affly
Maryland 2	should be filed and Mental Hygie marked other umatic event, II	To Be Co	17. Father's Name <i>(Firs</i> Goldthwai t	it, Middle, Last) ce H. Dor:	r		1		Virgi	nia Elber		
	od 2 sh lith and 27 is m r traum		19a Informant's Name Rosalind Pa	Relationship (Ty arkinson)	Daughter		19b Majjii 4332	ng Address (Street a Harborou	and Number o	or Rural Route Numi Columbus	per, City or Town, State, , OH 43220	Zip Code)
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 iry or other tra		20a. Method of Disposit 1 Burial 2 C 4 Donation 5	remation 3 🗆 R	lemoval from Sta	20b. P	Place of Disponentery, creates apea	psition (Name of matory or other place ke Cremat	ory In	ਾਗਿ 25 ic. 2007	20c. Location - City of Beltsville,	
Balti	permit. Pages 1 Department of H Important: If ite eny injury or ot once.		21. Signature of Funera	al Service License	99 iTh - 1	4014				eral Alter es Drive		aryland 21286-
760,	Physician /Medical Examiner white prival-transit phe prival-transit phe prival-transit phe prival-transit phe prival-transit phe prival-transit phenomena ph	lical Examiner	23a. Pert1. Efter the d shock, or heart fa Immediete Cause (Fina disease or condition resulting in death) Sequentially list condition famp, leading to immediate, senter Underlying Cause (Disease or injurthat infitiated events resulting in death) Last	ilure. List only or al ions, diate	Due to (or a Due t	as a consequas a consequant consequence	EME uence of):		9, 30011 43 44	in the second se		Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certificat tie has been signed by the attending phypage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mo 1 □ Yes 2 ☑ No 9 □ Unknown	nths?	23c. If yes, outcor 1 Ulive birth 4 Pregnant 9 Unknown	2 Fete	death 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Date of de Month	elivery Day Year
ds, P	w requires that been signed b should be deta	by	Part II. Other significan	nt conditions con	ntributing to death	h but not res	utting in the u	underlying cause giv	ven in Part I.		tobacco use contribute]Yes 2	to the cause of death? Probably 4 □Unknown
Records,		Completed	Arren	n/0	due	to.	6	I 61	ud	24a. Wa aut per 1 🗌 Yes	opsy prior to death?	autopsy findings available completion of cause of s 2 \(\text{No} \)
Vital	sician: certific rector.	o Be	25. Was case referred examiner?	_	Hospital: 1 □ Inpa	atient 2] ER/Outpatie	nt 3□ DOA Oth	200	of Death Check on	one) sidence 6 Other (Sp	ecify)
ion of	ding After fune	H	27. Mann of Death	5 Pending investigation	28a. Date of 1 (Month,		28b. Time o Injury	of 28c. Injur	ryat rk? ∣Yes 2 □ Ne		e how injury occurred	
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	Could not be determined	200. Flace U	Injury - At h etc. (Speci	ome, farm, s	reet, factory, office		28f. Location City or 7	(Street and Number or I own, State)	Pural Route Number,
	Hospita 24 hours Funeral etely filled	edical (29a. Certifier 1[(Check only 2[one)	Certifying Phy Medical Exami	rsician: To the beiner: On the basi	s of examina	owledge, dea ation and/or i	th occurred at the tinvestigation, in my	me, date and opinion, death	place, and due to the occurred at the time	e cause(s) and manner and die date and place, and die	as stated. ue to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title	e of certifier		otatou.		29c. Licens	se number		29d. Date signed (Mo	nth, Dey, Year)
	. 1		Bur	bara	Cav	sell.	m	y D	383	92	6/25/3	7007
	J's		30. Name and address	RA CI	ARRO	1-4	MD	, Print)	1 /	ORKRI	D., WOCKE	45'VILLE, 171
	St Regist	ate rar	31. Date filed (Month,	12.6.2007	Page 1	istrar's Sign	Soa	de)	-			,

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June 22, 2007 6:30 A. M Elmer L. Sherman, Sr. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A 3605 Buena Vista Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 23,1926 Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Days Months Hours 219-10-2341 1 X M 2 □ F 80 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits N/A Maryland Baltimore 1X Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 21211 3605 Buena Vista Avenue USA 12. Was Decedent Ever in U.S. Anned Forces? 1 1 yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Senior Citizen Elementary/Secondary (0-12) College (1-4or 5+) Apartment House Desk Clerk unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Robert Sherman Lillian Mules 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Sherman Wife 3605 Buena Vista Avenue, Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1558urial 2 ☐ Cremation 3 ☐ Removal from State Lorraine Park Cemetery 6/25/2007 Woodlawn, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final una cancer months disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an performed 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

"natural", or items edical Examiner m

or than "natur the Medical

traumatic event,

Item 27 other t

Department of Important: If It any Injury or conce.

Director

Funeral

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Completed

Be

P

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division or Vital Records,

and the burial-tra use as t page 2

Examiner Physician/Medical ð Completed Be P Certification:

be executed physician attending p signed by the been has certificate Physician: funeral director, this After t within 24 hours after death.

To the Funeral Director: filled in by ō Hospital

Medical completely State Registrar

5 ☐ Pending investigation

6 Could not be determined

PHYSICIAN

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28b. Time of

Injury

29c. License number D53590

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 22,2007 JUNE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 04 MO ROOM 609 SUDNE

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated.

624 N BROADWAY BALTIMORE MD 21205

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 Yes 2 No

Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

onel

4 Homicide

(Check only

JUN 2 6 2007



		•	1 - For Amend Item 26 per verb , 8868, 06/20/07dhb Certificate of Death	d Mental Hyg	giene Reg. No. () [] /	20539
915	D		1. Decedent's Name (First, Middle, Last)	Date of Dea Month	ath Day Year	3. Time of Death
п	Physici /Medic		Charles Sawyer	June	20, 2007	12:45A ^M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De	ath	4c. County of De	ath
			2421 Long Ridge Road Reisterstown		Balti	more
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H Months Days Hours Mi		h v. Year) 9. B	irthplace (State or Foreign Country)
	Director		133-28-8503 1X M 2 F 74 Yrs. Months Days Hours M	June 1		NY
	P .		Usual Residence of Decedent			Training on the
	irylar show	. I	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 11∕C Yes 2 □ No
	e Ma la-f s	용	NY St. Lawrence Ogdensburg			X res 2 100
	or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What 0	Country?
	th wi	<u>a</u>	923 Hasbrouck Street 13669		USA	
	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notifled at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	. 14. Race - An Black, Wh	
9	or It		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify:		Specify:	
5-0036	ours iral",	d b	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 53-57			White
5	72 h 'natu dica	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work done	vorking	16b. Kind of Busines	s/Industry
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pu	should be filed within nd Mental Hygiene. marked other than imatic event, the Me	Be	17. Father's Name (First, Middle, Last) 18. Mother's N	lame (First, Middle,	maiden Surname)	
<u>×</u>	Men arke	ပ္		Warren		
Maryland	2 sho and is mi		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or			, Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylar I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show then traumatic event, the Medical Examiner must be notitled at		Mark Sawyer Son 2421 Long Ridge Road			21136
altimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Date	20c. Location - City of	or Town, State
Ĕ	Pag nent ant: I		4□Donation 5□Other (Specify) Foxwood Mem. Park	-	In of Oswe	gatchie, NY
a	permit. Departr Imports any Inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility	1182	4 Reisters	town Road
B	8 8 E 8 8		Slepher M. Jonkson Eline Funeral Hor	ne Reis	terstown,	MD 21136
	E 1 E 1		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	liac or respiratory ar	rest,	Approximate Interval Between
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	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of).	in, auc	11000	+ years
	Examiner			1	noca	
9.5	· / 24	ē	seque fluity list or ultions if any, leading to immediate cause. Enter Underlying		1	
	uted d ansit	Examin	Cause, Enter Underlying Cause (Disease or injury that initiated events C.			
Ć,	n and	Exa	resulting in death) Last			
292	ficate be execut physician and s the burial-trar	le l	d			
68760,		edical				
Box	death cert e attending d for use a	Physician/M	IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 23c. If yes, outcome pf		23d. Date of d	lelivery
ğ	atte for i	cial	in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
P.0.	the d y the	ıysi	9☐Unknown 9☐Unknown			
	w requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	obacco use contribute	to the cause of death?
ds	uires sign d be	d by		1 🗆 🕆	Yes 2 No 3□	Probably 4 Unknown
Ö	requestion to the second secon	Completed		24a. Was	on Oth Word	autonov findingo ovoilable
ě	et (2 o)	dr		— autor	osy prior to	autopsy findings available o completion of cause of ?
=	ate pag	ပိ		1□ Yes	2 X 1 No 1 □ Y	es 2 No
Zi.	Ician Sertifi ector	Be	examiner?	Death (Check only o		Son's
or Vital Records,	> .0 0	은	1 Tes 2 Pro 1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursin			eResidence
Ē	Ing F	ü0	27. Manner of Death 1 ★ Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Injury 28c. Injury at Work?	28d. Describe	now injury occurred	
Division	tend eath tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury. At home farm, street, factory, office			
≅	or At ter d lirec n by	Ħ	3 Suicide 4 ☐ Homicide determined determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tou	Street and Number or vn, State)	нигаї ноціє митібег,
Ω	ital or ral craft	ပ္ပ		4		
	Hosp 4 hou Fune ely fi	cal	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical Certification:	one) and manner stated.		and Data de la Cal	anth Day V
	To with	2	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
	A W		Willen Il Forashire MD NO DOOZ	5++5	06-20	-200 t
11	T		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	10	PAIT	MAZIZ
	6		30. Name and address of person who completed cause of death (Herr 23a) (Type, Print) ARLENE H. FORASTIERE 1650 ORLEAN 31. Data filed (Month, Day, Year) 32. Peristrar's Signature	17 71	DHLI. 1	11D 21230
	Sta		31. Date filed (Month, Day, Tear)		•	
	Regist	ar	JUN 2 6 2007 Mercy S. Sparker			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Year **Physician** 10:35 AM MARIE June W. SCHMID 14 2007 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Square Hospita KOSEdale
If Under 24 Hrs. 8. Date Franklin Baltimore 8. Date of Birth (Month, Day, Year) 12 9. Birthplace (State or Foreign Country) Mary Land If Under 1 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Year **Funeral** Days 1 ☐ M 2 🖾 F 94 Yrs. 212-34-9559 Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: if item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at MD Harford Bel Air 1 ☐ Yes 2 HNo Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? USA 21014 1210 Ambridge Road Funeral I 2 should be filed within 72 hours efter death on and Mantal Hygiene. Is marked other than "natural", or items 23: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status 1 □Yes 2 □ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6 Housewife Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mantal Important: if item 27 is marked any injury Arena. Asmin Petersen Minnie Nolte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1210 Ambridge Road Bel Air, MD 21014 M. Harriet Cox- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 6/28/07 Baltimore, Maryland Parkwood Cemetery 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Charles S Zeiler & Son 6224 Eastern Avenue Baltimore, MD 21224 23a. Part Filter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, if heart fair to nly one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of): Physician/Medical Examiner ibrillation attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760. ongestive Heart Due to (or as a consequence of nemia Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à ate has been signe page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy THE PURE 1 ☐ Yes 2 ☐ No eftar death.

Director: After this cartification by the funeral director, 25. Was case referred to medical å 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 patient 2 ER/Outpatient 3□ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours of To the Funeral C To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JUNE 14, 2007 26237 47 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Paz 9000 Square Drive Baltimore MD. 21237 DR Kobert

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 6 2007

Chmidi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** TINSLEY EVELYN JUNE 19 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA HARBOR HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 Yrs. 12/9/2 225-36-3995 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Dyes 2 No Funeral Director Imone MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Booke 21225 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☐ Yo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Black Saltimore, Maryland 21215-0036 Specify: Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) House KEEPING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marry P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bathmore MD 21225 Ricardo Drive Tinsley 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 □Removal from State Family Cemptery! 6/25/07 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23. Part1. Enter the disease, or any loations that caused the death. Do not enter the mode of dying, such as cardiac or respiral ory arrest,

Approximate

Immediate Cause (Fine) 4 Donation 5 Other (Specify) Immediate Cause (Final COLON CANCER Physician YEAR METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ELLULITIS DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examiner requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records, Completed by 1 | Yes 2 | No 3 | Probably 4 Nonknown NEUTROPENIA phone 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No IHROMBOCYTOPENIX 24a. Was an has 2 No certificate CELLULITIS 1□ Yes or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 (Inpatient Medical Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Hospital 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) MD tel RESOOI

Registrar
DHMH 17 Rev 1/2001

State

BALTIMORE MD 21225-SEJAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

SOUTH HANOVER ST ,

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#20b perFH C868 6/26/07 WS
State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 0850 AM 23 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** nion Memorial DSPITO 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Age (In y s. last birthday) 5. Social Security Number **Funeral** Days Months 1**X** M 2□ F Hours 243-26-5934 Usual Residence of Decedent Director filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director MD ltimore 10g. Citizen of What Country? 10e. Street and Number US Olumbus Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Fes 2 ☐ No If Yes, Give 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📉 No Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life_DO NOT use retired) Elementa (7) adordary (0-12) College (1-4or 5+) Bethleba permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 Is marked other any injury or other traumatic event, # 18. Mother's Name (First, Middle, Maiden Surname) Be nant's Name/Relationship (Type. Print) mber or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of lto.MD :/Immous(Baltimore, 20c. Location - City or Town, State ethod of Disposition 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faneral Service Licensee vices 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HYPERTENSIVE **Physician** CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed the burial-tran and Due to (or as a consequence of) Box 68760. physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by CEREBRO VASLULAR 1 Yes 2 No 3 Probably 4 Wonknown cate has been s , page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? Yes 2 No certificate 1□ Yes or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D5059107 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTERSTOWN BUSINESS DRIVE MD)MA 32. Begistrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

JUN 2 6 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** RUTH 2007 TUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALLSTOWN BALTIMURE NIRTHWEST HOSPITAL CENTEN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Hours Months 1 □ M 2 💢 214.38.5851 صاصا 07/19/1940 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County a or 28a-f show t be notified at 28a-f show 1 XYes 2 No MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2512 Oakley Avenue items 23a 2 should be filed within 72 hours after death w and Mental Hyglene. is marked other than "natural", or items 23a raumatic event, the Medical Examiner must! Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health Superlisor 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If Item Z7 is marked any injury or any inju Moore Naomi Tatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Road Catonsville MD Moore Deerbrook Gerard Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Murial 2 □ Cremation 3 □ Removal from State Windsor Mill, MD 06/30/07 4 Donation 5 Dother (Specify) King Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral STVC Road Randalistown MD 21133 8728 Liberry 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIDVASCULAR ARTERIDSCLEROTIC **Physician** /Medical Due to (or as a consequence of): **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 Probably 4 □Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an was and autopsy performed?
Yes 25 No page 2 s 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00024970 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUAD RANDALLSTOWN 720 FABER, MO LVVOIT

State Registrar 2 6

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** RACHEL TORREGROSSA JUNE 25, 2007 3:15 P M /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** CARROLL HOSPICE - DOVE HOUSE WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day. 9. Birthplace (State or Foreign **Funeral** Months Days Hours NEW YORK 1 □ M 2 X F Director 5/11/1926 063-20-8372 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at HOWARD COLUMBIA 1 ☐ Yes 2 XNo Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11241 A CRYSTAL RUN 21044 USA filed within 72 hours after death thygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE HOME MAKER 12 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o JOHN LISI **JENNIE** CONSALVO 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RENE TORREGROSSA -HUSBAND 11241 A CRYSTAL RUN, COLUMBIA, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/2/2007 4 ☐ Donation 5 ☐ Other (Specify) CALVERTON, NEW YORK CALVERTON NATIONAL CEM. 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityFLETCHER FUNERAL HOME, P.A. 23a. Part1. Enter the risease, or implication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 254 E. MAIN ST., WESTMINSTER, MD 21157 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** concer -una /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician at s the burial-t Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) ed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à has been signed to should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy page performed' certificate 1∐ Yes 2 🕡 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 MOther (Specify)HOSPICE ဥ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 2 6 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

MD

29c. License number

29d. Date signed (Month, Day, Year)

2007

June

	מנ	Registrar 1. Decedent's Name (First, Middle, La	ast)	O e	ertificate of D	Juli	2. Date of Deat Month	h Day	Year	3. Time of Deat
Physici /Medic Examin	al	Francis J. 4a. Facility Name (If not institution, gir			4b. City, Town, or l	Location of Death	66	15 4c. Cou	2007 Inty of Death	7:13A
LAGITIII	्	4213 Darleigh Rd	L		N/A			Ba	altimo	re
Funeral Director		5. Social Security Number 6. 214-40-2279		(In yrs. last birthda) 65 Yrs.	y) If Under 1 Year Months Days	Hours Min.	8. Date of Birth Month, Day, 8/23/19	41 Year)	9. Birth	place (State or For intry) MD
3		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					10d, Inside City Lin
28a-f show	ō	MD Baltimo	re		N/A					1 ☐ Yes 2 X
r 28a	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen	of What Cou	intry?
23a c	alD	4213 Darleigh R	Rd.		2123			USA		
smer man	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	 Was Decedent of His If Yes, specify Cuban 	panic Origin? (Sp , Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White	
nt of Health and Menial Hygiene. : If item 27 is marked other than *natural', or items 23a or 28a-f shov or othar traumatic event, the Medical Evant restricts be troubled at	P P	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 🔼 No	Specify:				hite
natra	Completed	15. Decedent's E (Specify only highest gi	Education rade completed)	(Gi	cedent's Usual Occupative kind of work done du b. DO NOT use retired)	uring most of work		16b. Kind o	f Business/li	ndustry
than	dmc	Elementary/Secondary (0-12)	College (1-4or 5-	-) _	ireman			Ва	lto. C	ity
Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Las	st)			18. Mother's Nam	e (First, Middle, I			
fental	To B	Frank Vitak				Joseph	ine Dre	ssel		
and Mental Hygiene. Is marked other than aumatic event, the Me	-	19a. Informant's Name/Relationship	(Type, Print)	19b. Ma	ailing Address (Street a	nd Number or Rur	al Route Number	, City or To	wn, State, Zi	ip Code)
Department of Health ar Important: If item 27 Is any injury or other trau		Jeanette Vitak	:/Wife	_	Darleigh F				21236	
iten oth		20a. Method of Disposition		20b. Place of Dis cemetery, ci	position (Name of rematory or other place		Date	20c. Location	on - City or T	Town, State
ent ont: If		1 Burial 2 Cremation 3 Other (Spec	☐Removal from State :ify)	-	of Faith Ce		2007	Balt	timore	MA
Department Important: If any injury or once.		21. Signature of Funeral Service Lice	ensee -	parquis	22. Name and Address	s of Facility Sch	munek Fi	unera	1 Home	. Inc.
Depar Impo any ir		Busin a.	wee		9705 Belair					236
1-3 M		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused	the death. Do not e	enter the mode of dying	, such as cardiac	or respiratory arr	est,		Approximate
		shock, or heart failure. List only	y one cause on each lin							Internal Retuge
		Immediate Cause (Final	to i 1		en en i en eren e	L T	Uhana		W.	Onset and Deat
ysician Medical		Immediate Cause (Final disease or condition resulting in death)	- Metasto	Hic Ca	ncinoma	of T	ungue			Onset and Deat
Medical Kaminer		disease or condition	- Metasto	tic Ca	ncinema	of T	ungue	-		Onset and Deat
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Medical kaminer	Examiner	disease or condition resulting in death)	b. Due to (or as a	tic Ca	ncinoma	of T	v ngue			Onset and Deat
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Sune **Physician** Lee Nola Versace 20 07007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Jartoca Health and kemb (entex Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/13/1915 Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 ☐ M 2 🛣 F Yrs. 228-20-9662 92 Viginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 ☐ Yes 2X No Directo Maryland Harford Fallston 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe U.S.A. 3213 Suffolk Lane 21047 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: White þ 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Coflege (1-4or 5+) Elementary/Secondary (0-12) Restaurant Waitress 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Stump ပ Marshall Austin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3213 Suffolk Lane Fallston, MD 21047 Vincent O. Versace (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 06-23-2007 Baltimore, Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lie Schimunek Funeral Home Of Bel Air Juin 2 Inc. 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of defiver 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of fnjury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No

Examiner ed by the ettending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Box 68760 Be Completed by Physician/Medical of Vital Records, P.O. has or Attending Physician: Medical Certification: To Division death. 2 Accident within 24 hours after death
To the Funeral Director:
completely filled in by the 6 Coufd not be determined 3 Suicide 4 | Homicide the Hospitei 29a. Certifier (Check only one) 29b. Signature and title of certifier

Funeral

Director

with the Maryland

nd 2 should be filled within 72 hours after death with the Marylan lith and Mental Hygiene. 27 is marked other then "natural", or iteme 23a or 28a-f ehow treumatic event, the Modical Exeminar must be notified at

permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy, importent: if item 27 is marked othe any injury or other traumatic event, pages.

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0036

10

31. Date filed (Month) State

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DT6545

29d. Date signed (Month, Day, Year) 6/20/07

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#102, BELAIR, MD 21014 206 MAYS KHOSA 21 SHILPI

32. Registrar's Signature

28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

918 Country Club Rd Harve de Grace MD 21078

20c. Location - City or Town, State

filed within 72 hours after deeth with the Maryland r than "netural", or itame 23a or 28a-f ehow the Medical Examinar must be molified at Baltimore, Maryland 21215-0036 Pages 1 and 2 should be filed w iment of Health and Mental Hygie 1 ant: If Item 27 ie marked other t jury or othar treumatic event, permit. Page Department of Important: If eny Injury or once.

Physician

/Medical

Examiner

10a, State

Directo

Funeral

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Completed

Be

Cindy Williams (Daughter)

1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State

20a. Method of Disposition

Funeral

Director

Physician /Medical Examiner

> physicien end s the burial-transli attending ph been signed by the should be detached

Division of Vital Records, P.O. Box 68760,

	4 □ Donation 5 □ Other (Specify))	Bayview	Cremat	ory o	-21-20	UU/ Bali	imore,	Maryı	and
	21. Signature of Funeral Service Licens	500			Address of Facility	Schir	munek Fune Rd Bel Ai			el Air
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	plications that caused thone cause on each line.	ne death. Do not					.,	Approxim	mate Between nd Death
Be Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	consequence of)							
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eted by PI	Part II. Other significant conditions co	ontributing to death but	not resulting in th	ne underlying ca	use given in Part I.		23e. Did tobacco 1 Tes 2	5 2 <u>0</u> No 3 □ P	robably 4	Unknown
Сошр							autopsy performed?	death?	completion of	of cause of
Be	25. Was case referred to medical examiner?				26. Place	of Death (C	Check only one)			
ဥ	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpa	atient 3 DO	Other: 4 Nur	rsing Home	5 Besidence	6 ☐Other (Spe	ecify)	
ation:	27. Manner of Death 1 Aatural 5 Pending 2 Accident investigation		(ear) 28b. Tim Inju	e of 28	ic. Injury at Work?		d. Describe how inju	ry occurred		
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm (Specify)	, street, factory,	office	28f.	Location (Street at City or Town, State	nd Number or F 9)	lural Route N	lumber,
Medical Certification:	29a. Certifier 11 Certifying Phyone) 2 Medical Example 12 Medical Example 13 Medical Example 14 Medical Example 15 Medical Exam	ysician. To the best of parties: On the basis of example and manner state	xamination and/o	leath occurred a prinvestigation,	t the time, date and in my opinion, deat	d place, and h occurred	d due to the cause(s at the time, date an) and manner a d place, and du	s stated. e to the caus	6e(s)
W	29b. Signature and mile of certifier	2701	FACE	29c.	License number H3907	2	29d. Da	te signed (Mon	th, Day, Yea	007
	3d Name and address of person who c	1 508 R	249499	Print)	Way &	Loger	nd M	>		
te	31. Date filed (Month Pay Year)	7 32. Registrar's	s Signature	sell						

20b. Place of Disposition (Name of cemetery, crematory or other place)

State Registrar

within 24 hours a
To the Funerel C

07-04656 Patty May Vento

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2007 20548

•		1- For State	Certific	cate of l	Death				eg. No.		- 10	Time of Dogth
Physicia		Registrar 2. Date of Death 3. Time of Death 4. Decedent's Name (First, Middle,Last) Month And And And And And And And An										
ı Examir	ner	PATRICIA M. VENTO										
		4a. Facility Name (if not institution, give street and numbe	r)	41	o. City, Town, or Lo Middle River	ocation of L	Dealii			County of altimore	e County	,
		3300 Edwards Lane				If Under 2	24Hrs 8	R. Date of Bi	rth (MM/E	D/YYYY)	9. Birthpl	ace (State or
Funeral		o. obdiai obdanty i tamos	ge (In yrs. last bi	irthday)	If Under 1 Year Months Days	Hours		06/2			Foreign Countr	MD
Director		215-90-9417 1_M 2XF	42	Yrs.				00/2	1/ 1.		Count	
		Usual Residence of Decedent		1							10	d. Inside City Limits
any		10a. State 10b. County	10c. City, Tow								1	Yes 2 No
nd show	_	FLORIDA BROWARD	FT.	LAUD	ERDALE				10a Citi	zen of Wh	at Country	0
th the Maryland 23a or 28a-f show notified at once	Director	10e. Street and Number			10f. Zip Code			1		SA		
he M	Ö	1430 NW 114th AVE			33323						Amorica	n Indian, Black,
with t		11. Marital Status 12. Was Decede		13. Was	s Decedent of Hisp es, specify Cuban,	oanic Origir Mexican, F	n? (Spec Puerto Ri	cify Yes or N can, etc.)	0-	14. Race White		II IIIdiali, Didok,
eath item	Funeral	1 Never Married 2 Married Armed Force	2 No						7	Cassifi	WHIT	TE.
fter d l", or ler m	y F	3 Widowed 4 Divorced If Yes, Give Year			Yes 2 No			di dono			isiness/Ind	
ours a ntura camin	d by	15. Decedent's Education (Specify only highest grade of		 a. Deceden during m 	t's Usual Occupationst of working life.	DO NOT u	ina oi woi ise retired	d)	100.1	4110 01 00		
72 hc	omplete	Elementary/Secondary (0-12) College (1-4							0	WN H	IOME	ļ
036 ithin ne. r tha	μ	12		HOMEN	IAKER	18 Mother's	Name (First, Middle				
5-0036 iled within 7 Hygiene. d other than	ပိ	17.1 attict o Hamo (First Inc.)			4		ETA		,			
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the Medical Examiner	l &	WILLIAM ROPPELT		10h Mailin	Address (Stree			ral Route N	umber, C	City or Tow	vn, State, Z	Zip Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once transmatic event, the Medical Examiner	유			1430	NW 114	th A	VE I	PLANT	ATI	ON, E	L.	33323.
ME sell the		PHILLIP M. VENTO (HUS 20a. Method of Disposition	20b. Plac	ce of Dispos	sition (Name of cer	metery,		Date	20c.	Location	- City or T	own, State
Fe, Slar free Frie		1 Burial 2 Cremation 3 Removal from	State crer	matory or ot	her place)		n6 /	23/20	07	N. I	AUD	ERDALE, FL
Page Page lent o		4 Donation 5 Other Specify:	QUE		F HEAVE	4 = 1114						
alti mit partm ports ury o		21. Signature of Funeral Service Licensee		1 22. I	Name and Address ENRY W 5924 YO	JEN	KIN	SNKTS	QNS	CO,	5111	1
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other transmatic event, the Medici	Ì	23a, Part I. Enter the disease, or complications that cau		10	5924 YO	RK R	D Mo	respiratory	arrest, sh	nock, or he	eart I	Approximate interval
ıysician		failure list only one cause on each line.			the mode of dying.	, 000, 00						Between Onset and Death
/Medical Examiner		Immediate Cause (Final disease a. Carbon Mone		ation								
LXammo		or condition resulting in death) Due to (or as a c	onsequence or):									
	<u> </u>	Sequentially list conditions, if any, leading to immediate Due to (or as a condition).	onsequence of):									
	i	cause. Enter Underlying Cause										
N9. =	Evamine	(Disease or injury that initiated events resulting in death) Last	onsequence of):									
transit cuted . CC	μ Ε											
Sords, P.O. Box 68760, Isw requires that the death certificate be executed has been signed by the attending physician and cohortal to detached for use as the burial. Transit	Modical	UNPENDED							12	23d Date	of delivery	
Box 68760, a death certificate be the attending physic efforms as the burn	MA		utcome of pregna th	ancy	etal death 3	Ectopi	ic pregna	ncy		Month	_	oay Year
68 certifi	g 2		nt at time of deat		Other (Specify)							
eath c			٧n		_							the same of dooth?
tal Records, P.O. Box 687 rian: The law requires that the death certific certificate has been signed by the attending		Part II. Other significant conditions contributing to	death but not res	sulting in the	underlying cause	given in P	art I.					the cause of death? pably 4 Unknown
P.O. es that the	e della	<u> </u>										
ds, equire	ping							a	Vas an utopsy		prior to c	topsy findings available completion of cause of
law r	Z sho							1 ✓ Y	erformed es 2	1? No	death? 1 ✔ Ye	es 2 No
Re(The	bage				26.Plac	ce of Death	h (Check	only one)				
of Vital Records, rg Physician: The law require ther this certificate has been signed.	director, page	25. Was case referred to medical	patient 2 1	ER/Outpatie		Other ₄		ng Home 5	Res	idence 6	Othe	r; Scene
Physi C	la dir	O 1 Yes 2 No	of Injury	28b. Time o		jury at Wo	rk?	28d. Desci Subject	ribe how	injury occ	urred	ppovide
Anne	funeral	5 27. Manner of Death 20d. Date 20d.	Day,Year)	FOUND:	1	Yes 2	No					_
SiOr titend death ctor:	y the	2 Accident Investigation Jun 18, 2	tigation Jun 18, 2007 1300 118 1300 118 2007 28f. Location (Street and Number or Rural Ro							ural Route Number, City		
Division tal or Attendin rs after death	d in b	3 Suicide 6 Could not be	Could not be determined (Specify) Boat at marina or Town, State) 3300 Edwards Lane, Middle River, Md							, Md		
ie ou	/ filled	4 Homicide 29a. Certifier 1 Certifying Physician: To the bes			curred at the time.	date and p	place, and	d due to the	cause(s) and man	ner as sta	ted.
ne Ho n 24 l	completely	Medical Examiner: On the basis	of examination ar	nd/or investi	gation, in my opini	ion, death	occurred	at the time,	date and	l place, ar	id due to th	he cause(s)
To the To the To the	comp	29b. Signature and title of certifier	tated.			ense numbe			2	9d. Date s	igned (Mo	onth, Day, Year)
15		2 250. Signatur dand that St. St. St. St. St. St. St. St. St. St			0.0	C.M.E.			J	lune 19	, 2007	
13		6 //	e of dooth /ltc-	239)								
OCME		30. Name and address of person who completed cause Mary G. Ripple MD. Deputy Chief I	se or death (item Medical Exar	niner '	111 Penn Stre	et, Balti	more, 1	MD 2120	1			
		Wary Stylings	egistrar's Signat		2:16.15-							
Do-		ate 31. Date filed (Month, Buy), very	ور مراهم	S. Joseph								
Reg	التطاد	38 3 V U U U U U U U U U U U U U U U U U U		- 0								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.__ 1. Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death WILSON **Physician** 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne <u>Arundel</u> Hours Min. 8. Date of Birth (Month, Day, Year) NOV 2, 1935 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 E 269-30-3279 Ohio 71 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Anne Arundel Fort George G Meade 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4974 Stewart Ct 20755 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ⊟Yes 2 🛣 No Specify <u>გ</u> 3 ☐ Widowed 4 🛣 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Leroy Nicewaner Lucille Naomi James 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Loren Wilson/Son 4974 Stewart Ct Fort George G Meade, MD 20755 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory, Inc 6/22/07 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee C. Cremation Society of Maryland, 299 Frederick Rd Baltimore, MD Todd Dring 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of ly on cause on each line. Approximate Interval Between Onset and Death Ker Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Jivision or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy perform 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tes 2 🗌 No within 24 hours ofter death.

To the Funeral Director of completely filled in by the f 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month

6

Registrar

DHMH 17 Rev 1/2001

use of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

,	1- For State Certificate of Death Registrar		07 2055				
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)	Date of Death Month Day Year	3. Time of Death 0838 hrs				
vieurcai Examine	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	June 21, 2007 4c. County of De					
	77 Rowland Road Port Deposit	Cecil	E				
Funeral Director	Months Days Hours Min.	8. Date of Birth (MM/DD/YYYY) 9.	Birthplace (State or reign Maryland				
Director	220 – 17 – 9975 1 M XXF 33 Yrs. 34 Yrs. 35 Yrs.	12/25/1973	Country)				
E 200 10 -1240 2 2000 2000 2000 2000 2000 2000 200	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits				
land f show	MD Cecil Port Deposit		1 Yes 2XXNo				
r death with the Maryland or items 23a or 28a-f show must be notified at once.	10e. Street and Number 10f. Zip Code 77 Rowland Road 21904	10g. Citizen of What C	Country?				
with the s 23a c enotif	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec		nerican Indian, Black,				
r death with or items 23 must be no	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto R	ican, etc.) White, et					
safter	3 Widowed 4 X Divorced of Yes, Give Year 1 Yes XX No specify:	Specify: rk done 16b. Kind of Busine	white				
2 hour "natu	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of wo during most of working life. DO NOT use retired	d)	ne la				
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan Completed	12 5+ Teacher	Eleme Educat	ion				
1215-0036 dbe filed within 72 hours after fental Hygiene. narked other than "natural". event, the Medical Examiner o Be Completed by	· · · · · · · · · · · · · · · · · · ·	First, Middle, Maiden Surname)					
21215-0036 ould be filed within 7 do Mental Hygiene. s marked other than lie eyent, the Medical To Be Comple	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru	Blevins ral Route Number, City or Town, S	tate, Zip Code)				
e, MD 2121 1 and 2 should be f Health and Mental item 27 is marker r traumatic eyent,	Scott Robinson/ father 67 Kirk Rd. Pyles		03				
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. unt: If item 27 is marked other than "naturial", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Bell Alr Jun	Date 28, 20c. Location - City	, , , , , , , , , , , , , , , , , , , ,				
230	4 Donation 5 Other Specify: Memorial Gardens						
Balt permit Depart Impor injury	21 agrature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Ch And Cremation Se	apel rvicesForest	port Dr. Hill, MD				
Physician	25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or refailure. List only one cause on each line.	respiratory arrest, shock, or heart	Approximate Interval Between Onset and				
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		Death				
	or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.						
iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause						
ed nisit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
760, crate be executed physician and the burial - transit	d. X UNPENDED AMENDED 290 7/10/07 TT						
60, ate be exect bysician an reburial - tr	X UNPENDED ##3a,27,28a-f, perME,g869, 7/19/07 TT IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of deli	very				
ox 687 eath certifics attending p for use as th	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant	cy Month	Day Year				
). Box 68: the death certification by the attending sched for use as I Physician.	1 Yes 2 No 9 V Unknown 4 Pregnant at time of death 5 Other (Specify)						
b.O. By that the de detached for Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribut					
Records, P.C. The law requires that ficate has been signed , page 2 should be deter		1 Yes 2 No 3	e autopsy findings available				
Sord law red has be 2 shou	·		to completion of cause of				
Recording The The Trips	25. Was case referred to medical 26.Place of Death (Check or		Yes 2 No				
Division of Vital Records, P.O. rat of tending Physician: The law requires that t is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacher in the funeral director. Page 2 should be detacher in the funeral director.	examiner?	Home 5 Residence 6 ✔ C	ther: Scene				
n of Alter t	The state of the s						
Sior Attend death. death. by the by the catic	Natural 5 Pending Investigation Accident 3 X Suicide 6 Could not be determined 1 Suicide 4 Homicide Active						
Divi	3 X Suicide 6 Could not be determined (Specify) residence	or Town, State) 7 Rowland Rd. Port I	eposit, MD				
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and d	lue to the cause(s) and manner as	stated.				
To the Ho within 24 To the Fu complete!	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and thanner stated. 29b. Signature and title of Certifier 29c. License number	the time, date and place, and due to 29d. Date signed					
2	29b. Signature and the or certifier O.C.M.E.	June 22, 2007					
V 4	30. Name and address of berson who completed cause of death (Item 23a)						
OCME	Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 31. Date filed (Month, Day, Year) Registrar's Signature	21201					
State Registra							
Regiona	IIIN 2 6 2001						

			For State Registrar	State of Maryland /		artment of Hertificate of D			ene o	07	20551
			Decedent's Name (First, Middle, Last)					2. Date of Death			3. Time of Death
	Physici		Emory A. Welk					Month June	Day 20	Year 2007	1535 ^M
)	/Medic Examir		4a. Facility Name (If not institution, give str	reet and number)		4b. City, Town, or		buile		ty of Death	1232
	Exami		Harford Memorial Ho	spital		Havre de	Grace		Harf	ord	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last b	irthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			ace (State or Foreign
	Director		215-24-3539	^{4 2 F} 79	Yrs.	Months Days	Hours Min.	(Month, Day, Jan. 12.	1928	M.	aryland
	p .		Usual Residence of Decedent								
	unylar show	_	10a. State 10b. County	10c. City, To	wn or Lo	cation				11	Od. Inside City Limits
	Ba-f.	cto	MD Cecil		Co	lora					1 ☐ Yes ∯☑ No
	in th	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of	What Coun	try?
	23a	- E	39 Sterling Nesbitt	Court		21917			U.S.A		
	r de	Funeral	11. Marital Status	. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spanic Origin? (Spanic Origin?)	ecify Yes or No- Rican, etc.)		ce - Americack, White,	
36	or it	by Fu	1 Never Married 20 Married	1 ☐ Yes 2 ☑ No If Yes, Give		I Yes 2√2 No	Specify:			y: Whi	
8	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Examiner must be mutified at		3 Widowed 4 Divorced	Year or Dates:							
21215-0036	en 1 mg	Completed	15. Decedent's Educa (Specify only highest grade	completed)	(Give	lent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of work	ing	6b. Kind of I	Business/Inc	lustry
12	within ene. than "	Ę	Elementary/Secondary (0-12)	College (1-4or 5+)						- 1	
B	other	e C	17. Father's Name (First, Middle, Last)	ria.	inte	nance Mec	nanic 18. Mother's Name	(First Middle M		Indu	stry
Maryland	Q 22 D	8	Amos Welk					ne Heatho			
2	should by nd Menta marked	ြ	19a. Informant's Name/Relationship (Type	Print) 19	h Mailin	g Address (Street a				State Zin	Codel
≅	d 2 sho					terling N					21917
	s 1 and if Health item 27 other tr		Tommy Welk/Son 20a. Method of Disposition	20b. Place	of Dispo	sition (Name of				- City or To	
Baltimore,	Peges nent of int: If it		1 Surial 2 □ Cremation 3 □ Rea	noval from State cemet	ery, cren	natory or other place					
ij	ortani njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee			Red. Cem Name and Address				ore, l	
Ba	permit. Peges Department of Important: If i eny injury or once.		Signature of American Solvins Education			705 Belai		chimunek Nottingha			
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	itions that caused the death. Do		· · · · · · · · · · · · · · · · · · ·					Approximate
	Physician		Immediate Cause (Final	LANLOR L'UE VIMIT	01	alina					Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	Due to (or as a consequence	100:	religion					
	Examiner		1	rade has been	am	DUSCASE	,			į	
		9	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence		1/1/01/1/2					
1	uted	Examin	if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	PRUSTATE Ch	un						
ò	exec an an rial-tr		resulting in death) Last	Due to (or as a consequence	1						
8760,	cate be executed physicien and the burial-transit	dicai	d.	Chrunic oksta	uchi	15 Dum	y niste	Mer			
9	ntifica ng ph as th	Jed	IF FEMALE		_	J. J.)		1		
Вох	death certifi e ettending i id for use as	an/h	230. Was decedent pregnant	: If yes, outcome of pregnancy 1 Live birth 2 Fetal deat	h 3	Ectopic pregnancy	•			ate of delive	
	dea ne ett ed fo	sicia	in the past 12 months? 1 Yes 2 No	4☐ Pregnant at time of death 9☐ Unknown		Other (specify)			M	lonth	Day Year
P.O.	that the death certificed by the ettending of detached for use as	Physician/Me	9 Unknown								
	S LO O	by	Part II. Other significant conditions contri	buting to death but not resulting	in the ur	derlying cause give	n in Part I.	23e. Did toba	icco use cor	ntribute to th	e cause of death?
ğ	w require been si should t	te d						1 Tyes	2 ☐ No	3 🗌 Proba	ably 4 Munknown
Records,	ne law r has be	Completed						24a. Was an autopsy	24b.	Were autop	osy findings available
<u>~</u>	The ate has page	Ä		/				perform	No No	death?	2(1 No
of Vital	Physicien: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death				
<u>></u>	Physic this ce al dire	2	1 Yes 2 No	spital: 1 Inpatient 2 ER/C	utpatien	t 3□ DOA Other	r: 4 ☐ Nursing Ho	me 5 🗆 Residen	ce 6 🗆 Ot	her (Specify)
	ding P		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b.	Time of Injury	28c. Injury Work		28d. Describe how	v injury occu	rred	
Sio	Attending in death. Octor: After by the fune	cati	2 Accident investigation			M 1 □ Y	es 2 No				
Division	irect n by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, to building, etc. (Specify)	arm, str	et, factory, office		 Location (Streetly or Town, 	et and Num State)	ber or Rura	Route Number,
	Hospital or Attenc 24 hours efter death Funarel Director: tely filled in by the										
	To the Hospital or Attending Physicien: The I within 24 Hours after death. To the Funarel Director: After this certificate ha completely filled in by the funeral director, page	edicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	ian: To the best of my knowledger: On the basis of examination a and manner stated.	e, death nd/or inv	occurred at the time estigation, in my opi	e, date and place, a inion, death occurr	and due to the cau ed at the time, dat	ise(s) and m e and place	anner as sta , and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date sign	etd (Month, L	Day, Year)
	⊢ s ⊢ ō		11 410 C	110		NU	341_	-	6/21	102	
r	\ \		30. Name and address of person who com	oleted cause of death (from 22-	/Tunn	Print)			7	101	
	Y		SU SUD CILL	7 9 4 1111	(Type,	NE MI	& and	210	THE	i	
50	. Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Signature	Anna	119	V V)		10		
	Registr		JUN 2 6 2007	The Man 15 1							

eorge Wilson		Please Type or Print in Black Indelible Ink. Ensure All Copie		ble.	
seorge vviisori		State of Maryland / Department of Health and Mental Hy	ygiene	0.0	
		RegistrarCertificate*3i Death	Reg	No. (U	1 (1)
Physici		1. Decedent's Name (First, Middle,Last)	Date of Death Month	Day Year	3. Time of Death
Medical Exami	ner	0-6019E WI.1301 3R.	June 21, 20	07	0206 hrs
1				4c. County of Deat	h
1		Johns Hopkins Hospital Baltimore		N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	-	(MM/DD/YYYY) 9. Bi Forei	rthplace (State or
Director		216-06-9661 12M 2 F 24 Yrs. Months Days Hours Min.	June 12		puntry) M.D.
		Usual Residence of Decedent	124.16 /2	700	
, any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
nd show	'n	m.J. N./A. BATTIMORE			1 Yes 2 No
Maryland 28a-f show d at once.	ctc	M.D. N/A BATTIMORE 10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cou	intry?
5-0036 led within 72 hours after death with the Maryland lygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Director	702 Gorsuch Ave 21218		21.5.A	
vith t		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-		ican Indian, Black,
ath v	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc.	real inglair, black,
ier de		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 1 No specify:		Specify:	1 land
is af ural	by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of w	vork done	6b. Kind of Business	Industry
2 hou "nat	teo	Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)		ob. King of Edsifiess	industry
36 vin 7. than dical	ple		8	shoe	Stan
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	17. Father's Name (First, Middle, Last) 18. Mone Shoe Repairm, 18. Mother's Name	(First Middle Ma	S/10C	SKUP
	Be C		(First, Middle, Ma	(
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	To B	19a. Informant's ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F	Pural Poute Number	or City or Town State	7in Codo)
5 5 5 E	_			•	
e, MC I and 2 sl Health ar item 27		Deborbs Wilson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date /577	20c. Location - City of	7) () 2 (2/ 8) Town, State
Baltimore bermit. Pages 1 a Department of He Important: If it		1 Burial 2 Cremation 3 Removal from State crematory or other place)			
		4 Donation 5 Other Specify: King Mem PR. Ja	16 27, 200	7 Randalls	town, MD
Baltii permit. I Departm Imports		21. Signatury of Funeral Service Licensee 22. Name and Address of Eacility Betts Luner Betts Betts Luner Betts Betts Luner Betts Luner Betts Betts Luner Betts Be	al ste	me	macri a not be a conse
))	Latriced Sille 1129N. CAROLIN	165T. E	solt more	MD 2/2/2
Physician		28a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	r respiratory arres	t, shock, or heart	Approximate Interv Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Gunshot Wound of Head			Death
		or condition resulting in death) Due to (or as a consequence of):			
	L	Sequentially list conditions, b			
	i.e	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			
	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
e executed cian and rial - transit		d.			
exectian and ital - t	Physician/Medical	UNPENDED AMENDED			
Sox 68760, leath certificate be eattending physici for use as the buri	Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	1
Box 68760, each certificate be attending physical for use as the but	ju j	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregna	ncy		Day Year
ox 6	ici:	4 Pregnant at time of death 5 Other (Specify)			
Bo) he deat the att	ķ	9 Unknown			
Records, P.O. Box 68760, The law requires that the death certificate be icate has been signed by the attending physicipage 2 should be detached for use as the burn	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to	
ires i	귷		1Yes	2 No 3 Pro	bably 4 Unknown
cords aw requi has been 2 should	ete		24a. Was an autopsy		utopsy findings available completion of cause of
eco ne law te has ge 2 s	Completed		perform	ed? death?	
tal Rec		25. Was case referred to medical 26.Place of Death (Check of D	1 Yes 2	No 1 Y	es 2 No
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sted in by the funeral director, page 2 should the complete of the control of the control of the funeral director, page 2 should the funeral director.	Be	examiner? Hospital:		esidence 6 Othe	<u> </u>
of Viiing Physical After this uneral direction	P	1 ✓ Yes 2 No Impatient 2 ✓ Erroutpatient 3 DOA 4 Nursin 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe ho		·····
nding Pt nding Pt h. : After e funeral	<u>.</u>	(14.4) 5.34-4	Subject shot	ga.y coodca	
Sior Attend r death ector: by the	cat	2 Accident Investigation 28e Place of Injury. At home form street factory office building ste	206 Leasting (Ctr	and and Number of D	
Divis pital or At ours after d eral Direc	Certification	Suicide Could not be determined (Specific Land)		eet and Number of Ri te) venue, Baltimore, I	ural Route Number, City
Division To the Hospital or Atten within 24 hours after death To the Funeral Director:	ပီ	20a Cortifor			
he Ho in 24 he Fu	ca	(Check only Certifying Frigstelan: To the best of my knowledge, death occurred at the time, date and place, and			
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	and manner stated.			
	Σ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	inth, Day, Year)
T		Petrillionis Blok us O.C.M.E.		June 21, 2007	
(0)		30. Name and address of person who completed cause of death (Item 23a)			
		Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 21201		
04	nto.	31. Date filed (Month, Day, Year) 32 Registrar's Signature			

Registrar

DOME

Division or Vital Records, P.O. Box 68760.

		For		State of Ma	ryland	•			Mental Hy	/gien	е		
		1 - State Registrar				Cer	tificate of	Death	1	Reg. No		7	20550
Physic /Medi		1. Decedent's Name Helen	e (First, Middle, La	Margaret		Wil.	es		2. Date of D Month June	eath Da 23	3, 20	ear 007	3. Time of Death
Exami				re street and number)				r Location of Deatl	h		c. County of		
		5. Social Security N	1 Tower		/la	A belockhoden A	Pasader		8. Date of B		Anne A		
Funeral Director		216-14-1	.574	r 2	(In yrs. lasi	Yrs.	Months Days	Hours Min.	July 2	ay, Year 17,19	13	Coun.	ace (State or Foreign try)
ryland how		Usual Residence of 10a. State	10b. County		10c. City, T	own or Lo	cation					10	Od. Inside City Limits
e Ma 3a-f s tiffied	Director	MD	Anne Ar	unde1		Pasa	lena						1 Tyes 2 No
vith th	Dire	10e. Street and Nu					10f. Zip Code				itizen of Wh	at Coun	try?
sath v s 23a nust	eral	-	1 Tower	Crossing 12. Was Decedent E	uns in II C	10.1	21122	lianania Oriain? (C	ensify Vac or N	U.S.	A .	Americ	an Indian
permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	81/0 Bell Tower Crossing 11. Marital Status 1						Vas Decedent of H f Yes, specify Cub: I □ Yes 2\text{\$\$\text{\$\exititt{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$\text{\$	to Rican, etc.)	0-		White,	etc.	
72 hc "natur	Completed	(Spec	15. Decedent's E	ducation ade completed)	1	16a. Deced (Give	lent's Usual Occup kind of work done OO NOT use retired	pation during most of wor	rking	16b. h	Kind of Busi	ness/Ind	lustry
within ene. than	d mc	Elementary/Seco	ondary (0-12)	College (1-4or 5-			Maker	2)		Own	n Home	4	
filed Hygi other ent, t	Be C	17. Father's Name	(First, Middle, Lasi	······································				18. Mother's Nar	ne (First, Middle				
uld be Menta arked	To B	Thomas Mo	cWilliams					Lena					
2 sho and I Is me	ľ	19a. Informant's Na					g Address (Street						,
1 and Health em 27 ther t		20a. Method of Disp		Daughter			Bell Towe				ocation - C		
Pages tment of tant: If it		1 X Burial 2 4 Donation	☐Cremation 3 ☐ 5 ☐ Other (Speci			Have	sition (Name of natory or other place en Mem. F	ark 20	07	G1e	n Bur	nie,	MD
permit Depar Impor any in		21. Signature of F	ineral Service Live	psee MOVE	364	- 1	. Name and Addre Second A		-				-
演		23a. Part1. Enter t	he disease, or con	plications that caused one cause on each lip	the death. I	Do not ent	er the mode of dyin	ng, such as cardia	c or respiratory	arrest,			Approximate Interval Between
Physician		Immediate Cause (disease or conditio	(Final	_a.	Dear	Fresc	na						Onset and Death
/Medical Examiner		resulting in death)		Due to (or as a	consequer	nce of):							
\$. A	er	Sequentially list co if any, leading to in cause. Enter Unde Cause Olisease or	nditions, nmediate	b	ı consequer	nce of):						+	
cuted nd ransit	Examiner	i mai minateu events		C									
cate be executed physician and the burial-transit		resulting in death) I	Last	Due to (or as a	ı consequer	nce of):							
physic the b	dical		•	d								+	
leath certific attending p	n/Me	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome p							23d. Date	of delive	ry
death le afte	Physician/Me	in the past 12 1 🗆 Yes 2	months?	1□Live birth : 4□Pregnant at 9□Unknown			Ectopic pregnanc Other (specify) _	у			Mont	h	Day Year
at the d by the etache	Phys	9 Unknown	77.7		t not rocultie	a in the u	adorfuina oguso giv	ron in Bort I	220 Did	tobacco	uco contrib	uto to th	e cause of death?
The law requires that the death certificate has been signed by the attending age 2 should be detached for use as	by	Romal Fo	I Luce	contributing to death bu	t not resulur	ig in the un	idenying cause giv	enin Pani.				□ Prob	
v requ	etec		, (NSE)	- 16					24a. Wa	e an	24h W	are autor	osy findings available
The law e has age 2 s	Completed								auto per	opsy formed?	pri de	or to cor	npletion of cause of
ian: T	Be C	25. Was case refer	red to medical					26. Place of Dea	1 Yes ath (Check only	2 N one)	0 11	Yes	2 & NO
hysica his ce I direc	To B	examiner? 1 ☐ Yes 2	No	Hospital: 1 ☐ Inpatier	nt 2□ER	/Outpatien	t 3 DOA Oth	er: 4□ Nursing H	lome 5.2⊠Res	sidence	6 □Other	(Specify)
ing P		27. Manner of Deat	5 Pending	28a. Date of Injur (Month, Day		Bb. Time of Injury	Wor		28d. Describe	how inju	ury occurred	d	
ttend death. ctor: /	icati	2 ☐ Accident 3 ☐ Suicide	investigatio 6 ☐ Could not b	e 200 Place of inju	ry - At home	farm str		Yes 2 □ No	28f Location	(Stroot a	and Number	or Rura	I Route Number,
ital or A irs after ral Direc	Certification:	4 ☐ Homicide	determined	building, etc	. (Specify)				City or To	own, Stai	te)		
To the Hospital or Attending Physician: The lwithin 24 hours after death. To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)		nysician: To the best o miner: On the basis of and manner sta	examination								
To the Com	Ž	29b. Signature and	title of certifier	a (T	0	5	29c. Licens	e number	-1	29d. Da	ate signed	Month, I	Day, Year)
n				- UZ V	oth /tto or	Pa) (Tront	Drint)	12133)	J W	ne 1	7)	LVV)
2		Name and add	ess of person who	completed cause of de	eatn (Item 23	305	1050	112 Peter	9 61	nBi	200	col-	2106/
St Regist	ate	31. Date filed (Mon	11111	32. Registra	r's Signatur	е	16		1				
DHMH 17 Rev 1/2			JUN 2 6 2	007 Januar	15	Popular	W.	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

James G. Wallis 07-04286 UNK UNK

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State of Maryland / Department of Health and Mental Hygiene

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		I-For State Registrar		icate of l					. No.		
Physici	an/	Decedent's Name (First, Middle,Last)					2.	Date of Death Month June 5, 200	Day Yea	3. Time of D	
ral Exami		James G. Wallis 4a. Facility Name (if not institution, give street	et and number)	4b	City, Town, o	or Location of	Death	June 5, 200	4c. County of		
		1100 W. Cromwell Ave	,		Baltimore						
Funeral		5. Social Security Numberink 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Ye		Min			9. Birthplace (State Foreign	
Director		1 X M	2_F 53	Yrs.	MOTUTS D	ays Hours	IVATS.	Feb 7,	1954	CountryMary	yland
ny		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location	n					10d. Inside	City Limits
d how an		MD Harford		vre de						1 Yes	2 X No
arylan	Director	10e. Street and Number			10f. Zip Code			10	g. Citizen of Wh	nat Country?	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ij	420 N. Stokes Stree	t			210			USA		
th with	Funeral	11. Marital Status 12. Never Married 2 Married	Was Decedent Ever in U.S. Armed Forces?			Hispanic Origii an, Mexican, I		ify Yes or No- can, etc.)		- American Indian, E e, etc.	3lack,
er dear , or it	교	3 Widowed 4 X Divorced If Yes	Yes 2 X No	1 ,	Yes 2 X	No specify:			Specify:	white	
nurs afi Itural' amine	Completed by	15. Decedent's Education (Specify only high	ates:	6a. Decedent's		pation (Give ki			16b. Kind of Bu	isiness/Industry	
6 172 hc an "na cal Ex	lete	, , ,	College (1-4 or 5+)		-	ile. DO NOT u	ise remed				_
withir giene.	omp	12 17. Father's Name (First, Middle, Last)	0	car	penter unk	18.Mother's	Name (F		nome 1m laiden Surname	provement	S
21215-0036 und be filed within 7 Mental Hygiene. marked other than	Be C	17. Father's Name (First, Middle, Last)			dik	1		Samps		,	
212 ould b d Men s marl	To E	19a. Informant's Name/Relationship (Type,	Print)							n, State, Zip Code)	
MD and 2 sho alth and m 27 is aumati		John Sampson/cousi		101 S				e de G	race, M	D 21078 - City or Town, State	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 R	i i	matory or other		cerriciory,		Buto	200, 2000.00		
timatriment ritant:		4 Donation 5 X Other Specify: 11	state	22 Na	me and Addr	ess of Facility	_			-	
Bal permi Depa Impo injur		21. Signature of Funeral Service Licensee Rona Ld S Wa	de, Director	Sta Bal	te Ana	tomy Bo	oard 21201	655 W.	Baltim	ore Stree	t
Physician		23a. Part I. Enter the dispase, or complication failure. List only one cause on each line	ons that caused the death. D	o not enter the	e mode of dyir	ng, such as ca	rdiac or r	espiratory arre	est, shock, or he	eart Approxim	ate Interval Onset and
Medical Examiner	10 00	Immediate Cause (Final disease a. At	herosclerotic ca	rdiovaso	cular di	sease				D	eath
		or condition resulting in death)									
	Jer		o (or as a consequence of):								
/	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	to (or as a consequence of):								
executed an and al - transit	ŭ	d					-				
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tox 68760, eath certificate be a strending physicis for use as the burit	sician/Med	IF FEMALE: 23b. Was decedent pregnant in the 1	Bc. If yes, outcome of pregna	incy			: pregnan	су	23d. Date o Month	f delivery Day	Year
x 68 th cert ttendir r use a	icia	past 12 months? 1 Yes 2 No 9 Unknown g	Pregnant at time of death	<u> </u>	ner (Specify)						
. Box he death of y the attenty the detents	Phys		Unknown tributing to death but not resi	ulting in the u	nderiving caus	se given in Pa	rt I.	23e. Did to	bacco use cont	ribute to the cause of	of death?
P.O.	\$	Tarris office significant contains to		g	,	3		1 Yes	3 2 No 3	Probably 4	Unknown
'ds, require seen si	Completed					_		24a. Was		Were autopsy finding	
Records, The law require	ᇛ				_				rmed?	death?	No
tal Rec ician: The l certificate l		25. Was case referred to medical			26.P	ace of Death	(Check or				
of Vital ng Physician After this certi		examiner? Hosp 1 ✓ Yes 2 No	I inpatient 2 L	R/Outpatient	-	Other ₄				✔ Other: Scene	
ion of tending Pheath.										rred	
Sior Attend death ector:	gŧ;	2 Accident Investigation	28e. Place of Injury - At hom	ne farm stree	at factory office			28f. Location (Street and Num	ber or Rural Route N	lumber, City
Division pital or Attendious after death.	Certification:	3 Suicide 6 Could not be determined	(Specify)	no, iaim, su oc	X, 100.01 y, 011.	30 2 a. a. r. g. a.		or Town, S			
ie ou		29a. Certifier 1 Certifying Physician:	To the best of my knowledge	e, death occur	red at the time	e, date and pla	ace, and o	due to the caus	se(s) and mann	er as stated.	
To the Hos within 24 h To the Fun	Medical	one) 2 Medical Examiner: On	the basis of examination and manner stated.	d/or investigat	ion, in my opii	nion, death oc	curred at	the time, date	and place, and	due to the cause(s)	
F > F 3	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (M						ear)		
		Milina Drassel	1111		0	.C.M.E.			June 6, 2		
		30. Name and address of person who com Melissa Brassell, MD Assis	pleted cause of death (Item 2 stant Medical Examine		enn Stree	t, Baltimore	e, MD 2	21201			
	State	31. Date filed (Month, Day, Year)	32. Segistrar's Signature	e -							
Regi			A/ 0	A.C.	Nº D						

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Jeremy Elijah Ya		1- For State	ate of N	/laryland		artment of			Menta	al Hy		g. No.	7	00055
Physicia		Registrar 1. Decedent's Name (First, Midd	le,Last)	-						2	2. Date of Death	1	3.	Time of Death
Medical Exami		JEREMY	FIT	JAH YAF	DDAV						June 16, 2	Day Year 007		2039 hrs
1		4a. Facility Name (if not institution					4b. City,	Town, or Lo	ocation of	Death		4c. County of E	eath	
		159 Mahaghany Dr.					Nortl	heast				Cecil		
Funeral		5. Social Security Number	6. Sex	7. Ag	e (In yrs. I	last birthday)	If Und	der 1 Year	If Under	24Hrs.	8. Date of Birtl			ace (State or
Director			1_XM	2 5		20 Yrs	Mont	hs Days	Hours	Min.	00/00	/1.007	oreigrp j	ENNSYLVANI.
	ŀ	unknown Usual Residence of Decedent	'LA'''			20 Yrs	<u>"</u>			<u> </u>	02/23	/198/		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
any .		10a. State 10b. County			10c. City	, Town or Local	tion						10	d. Inside City Limits
*		DDI MINDE	·m . 0.0				2011						1	X Yes 2 No
rylan a-f st	횴	DELAWARE KEN 10e. Street and Number	T CO.				DOVE 10f. Zi				110	g. Citizen of What		
e Mai or 28	Director	roc. offect and runiber					101. 21	p code			10	g. Chizen of What	Country	,
vith the Maryland s 23a or 28a-f show a notified at once.		135 HAMAN DE					<u> </u>	1990				U.S.A.		
ith wi	Funeral	11. Marital Status 1 XXvever Married 2 N		Was Decedent Armed Forces?				lent of Hisp ify Cuban,			cify Yes or No- lican, etc.)	14. Race - A White, e		Indian, Black,
or des	리		1_		X No									
s afte	þ		orced If Yes	tes:		1 1		ZXX No				Specify: E		
hour natu	Completed	15. Decedent's Education (Spe		ollege (1-4 or		16a. Deceder during m		orking life. I				16b. Kind of Busin	ess/indu	istry
36 in 72 han '	ple	Elementary/Secondary (0-12)		ollege (1-4 or	5+)	LINITAN	DIO	, IDD			W.	27 (7		
5-0036 Ied within 7 Hygiene. I other than	E I	10th grade 17. Father's Name (First, Middle	l ant\			UNEM	PLOY		O Moth orlo	Name /	First Middle N	N/A laiden Surname)		
THE THE		17. Fauler's Name (First, Middle	, Last)					16		- '		,		
2121 vuld be fi Mental I marked	o Be	DAROL KILSON 19a. Informant's Name/Relations		Print \		10h Mailin	a Addres	e (Street	MA.	RGO	M YARBI	RAY ber, City or Town, :	State 7	n Cada)
Shou and N 7 is n	٩					-0								19720
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland cealth and Mental Hygiene. ten 27 is marked other than "natural", or items 23a or 28a-f she trammatic event, the Modient Examiner must be notified at once.	- 1	Larry L. Yark 20a. Method of Disposition	ray.	Sr./Brc		Place of Dispos	EL1Z	abeth	<u>1 Swe</u>		riar Ln Date	 New Ca 20c. Location - Ci 		
2		1 Burial 2 XXCrematio	n 3 Re	emoval from St	ate	crematory or of	ther place	e)	,			CHESTER	-	
Baltimo permit. Page Department of Important: injury or ott		4 Donation 5 Other S	oecify:		H	AVEN ME						PENNSYI	VAN:	IΑ
Balti permit. Departin Imports		21. Signature Funeral St. 16	Leer ee			22. I W T	Name and	d Address of	of Facility	COM	יידאוואדיי	FUNERAL	номі	E P.A.
Ш & Ω ∴ .≡ .			velelle			112	06 W	NORT	'H AV	Ε.,	BALTO.	MD 21217		
Physician		23a. Part Enter the disease, of failure. List only one cause			the death	n. Do not enter t	the mode	of dying, s	uch as car	rdiac or i	respiratory arre	est, shock, or heart		Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease	N. A IA		ot Wour	nds and Blu	nt Ford	ce Injury						Death
z,cillioi		or condition resulting in death)	Due to	o (or as a cons	equence o	of):								
	_	Sequentially list conditions,	b	,									-	
	je	if any, leading to immediate cause. Enter Underlying Cause		o (or as a cons	equence o	of):								
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xecuted	Ω		d											
iO, e be executed ysician and burial - transit	edical	UNPENDED	AM	ENDED										
60, ate be shysic e bur	Mec	IF FEMALE:	230	c. If yes, outcor	ne of preg	nancy						23d. Date of de	livery	
P.O. Box 6876 that the death certificat ned by the attending phy detached for use as the	ian/M	23b. Was decedent pregnant in t past 12 months?		Live birth	, ,	promo	etal death	3	Ectopic	pregnan	су	Month	Day	Year
ath ce	sici	1 Yes 2 No 9 Un	known 4	Pregnant at	time of de	eath 5 0	ther (Sp	ecify)						
B G des	3		a	Unknown										
P.O. ires that the signed by t	by P	Part II. Other significant condi	tions contr	ibuting to deat	h but not r	resulting in the	underlyin	ig cause giv	ven in Pari	t 1.		bacco use contribu		
S, F											1 Yes	2 No 3	Probab	ly 4 Unknown
Division of Vital Records, tal or Attending Physician: The law requir is after deat. After this certificate has been sited in by the funeral director, page 2 should be	Completed										24a. Was a autops			sy findings available pletion of cause of
ecc ne lav te ha	Ĕ										perfor	med? dea		2 No
Vital Rec ysician: The linis certificate	ပ္	25. Was case referred to medica	ı I					26.Place o	of Death (Check or			163	2
Vita hysician this cer	e B	examiner?	Hospita	al: 1 Inpatie	ent 2	ER/Outpatien	1 3		Whor:			Residence 6 🗸	Other: Se	cene
n of V ding Phy After th funeral d	+1	1 Yes 2 No 27. Manner of Death	1 2	8a. Date of Inju		28b. Time of		28c. Injury				ow injury occurred		
nding the fun	힐	1 Natural 5 Pen		FOUND: Day, \	ear)	FOUND:			es 2 🗸 I	9		ten ánd shot		
ivision I or Attendi after death Director:	Certification:	2 Accident Inve	stigation 🖃	Jun 16, 2007		2039 hrs nome, farm, stre	et factor		_		28f Location (S	treet and Number	or Pural	Route Number, City
S after of in Dir.	ξl	dete	id not be		DUNI	Δ	Ct, ladioi	y, onice bu	many, ctc.		or Town, St	tate)		riodic rambor, only
in the local pine.		29a. Certifier	1		rking Lo			- 41-		- /21		ny Dr., North Eas		
To the Hos within 24 h To the Fur	ical	(Check only 1 Certifying Pone) 2 Medical Exa	hysician: T	o the best of m ne basis of exa	y knowled mination a	ige, death occu and/or investiga	rred at th	e time, date	e and plac death occi	ce, and d urred at	lue to the cause the time, date a	e(s) and manner as and place, and due	stated.	ause(s)
To the within 2 To the Complet	Medical		and r	nanner stated.				3c. License						
	2	29b. Signature and tille of certifi	//				28					29d. Date signed		Day, rear)
		* 1//		~				O.C.N	1.E.			June 17, 200	/	
O OCN	E	30. Name and address of person						_						
<u></u>		Mary G. Apple MD.	Deputy	Chief Medi				Street,	Baltimo	re, ME	21201			
		31. Date filed (Month, Day, Year)	2007	32. Registra	r's Signat	ure Spa	a							
Regist	ueii	JUNAU	7001	MACHELLAN.	- 50	18								

			1 - For State Registrar	State of I	Maryland / De <i>C</i>	oartment o e <i>rtificate</i> d				iene	17	20555
			1. Decedent's Name (First, Middle	e, Last)					2. Date of Deat Month		Year	3. Time of Death
	Physici /Medi		Ljubica Yurcan						June	'	207	9:45 P M
	Examir	ner	4a. Facility Name (If not institution		er)	4b. City, Tow	m, or Location	n of Death		4c. County	of Death	
			Keswick Multi-(5. Social Security Number		Age (In yrs. last birthda		imore	er 24 Hrs.	8. Date of Birth	n/a	O Dieth	alone (State or Foreign
	Funeral Director		106-48-7306	1□M X □F	93 Yrs.		ays Hours	s Min.	(Month, Day, Feb. 23		Cou	place (State or Foreign ntry) Datia
	D		Usual Residence of Decedent						100. 25	1/14		
	show	_	10a. State 10b. County		10c. City, Town or						,	10d. Inside City Limits 1 ☐ Yes X☐ No
	the M	Director	MD Balti 10e. Street and Number	more	Hunt V	alley				0g. Citizen of V	What Cou	
	with or			0.5		210			"	_	viiai Cou	nuy?
	me 23	Funeral	41 Winterberry 11. Marital Status	12. Was Decede	nt Ever in U.S. 1	3. Was Decedent	of Hispanic (Origin? (Spe	city Yes or No-			can Indian,
36	4 within 72 hours after death with the Maryland Jiene. r than "natural", or Iteme 23a or 28a-f show the Madical Examinar must be codified at	by Fur	1 Never Married 2 Marri 3 Widowed 4 Divorced	If Yes, Give	∑ No	If Yes, specify (Rican, etc.)	Specify	k, White, wh	etc. nite
Maryland 21215-0036	2 hou	ted	15. Deceden	t's Education	16a. De	cedent's Usual O	ccupation			16b. Kind of Bu	siness/In	ndustry
215	P. Bra "n. Madi	Completed	(Specify only highe: Elementary/Secondary (0-12)	st grade completed) College (1-4)	life	ve kind of work do . DO NOT use re	one during m etired)	ost of working	ng			
2	- '- L' -	Con	8	n/a		Homemake				Own H		
Ind	d ta b	Be	17. Father's Name (First, Middle,	Last)					(First, Middle, A	<i>Maiden Sum</i> am	Θ)	
3		၉	Sime Adum	his (Time Driet)	105 14	10 - Add (O)			ndijas	City Town	Charles Til	2-1-1
S	d 2 7 m tra		19a. Informant's Name/Relations Violet Sokolik/			iling Address (St				10.01.9		
	1 an Heat Fm 2		20a. Method of Disposition		20b. Place of Dis	interber position (Name o	ry Ct.			MD 2 20c. Location -		
JO.			1 ☐ Burial 2 ②Cremation 4 ☐ Donation 5 ☐ Other (S		110	rematory or other rematory	1	6/28/	07 6.	. t on oved	11.	MD
Baltimore,	permit. Page D partment of in portant: If any njury or or e.			Licensee		22. Name and A	ddress of Fac	cility		atonsvi		
苗	0 1 1 0	ic.	Michae	Flagle		Lemmon F IO W. Pa	uneral donia	Home Rd.	of Dula Timonium	ney Va	1093	, Inc.
			23a. Pert1. Enter the dis 19 m, s shock, or heart failure. List	complications that cause only one cause on each	sed the death. Do not a	enter the mode of	dying, such a	as cardiac o	r respiratory arre	est,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	A	nemia	OF CH	RUN	IC I) is ca	SE.		Onset and Death
	/Medical Examiner		resulting in death)		as a consequence of):							
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	uted I	Examine	cause. Enter Underlying Cause (Disease or injury	(
Ó	be executed sicien and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or	as a consequence of):							
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	Ca		d								
89	ing ph	Med	IF FEMALE:							-1-		
Вох	Jeath certifica attending ph d for use as ti	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	BEctopic pregn				23d. Dat Mo	e of deliv	ery Day Year
<u>o</u> .	e = £	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9⊡ Unknow		5 ☐ Other (specif)	v)					,
Δ.	that the		Part II. Other significant condition	ons contributing to deat	h but not resulting in the	underlying cause	e given in Par	rt I.	23e. Did tob	acco use conti	ribute to t	the cause of death?
of Vital Records,	The law requires that Ite has been signed b page 2 should be deta	d by							1 □ Ye	s 2 No	3 🗌 Prol	bably 4 Unknown
00	law requir as been si 2 should	Completed							24a. Was a		Vere auto	opsy findings available
ž	The lav	mo							autops perform	ned? c	rior to co feath?	empletion of cause of
ta	sician: Th cerificate irector, pag	Bec	25. Was case referred to medical examiner?				26. Pla	ace of Death	Check only on			
<u>></u>	S S D	<u>و</u>	1 Yes 2 No	Hospital:					ne 5 🗌 Reside			fy)
Ë.		ertification;	27. Manner of Death 1 Natural 5 Pendin	9	njury 28b. Time Day Yea <i>r)</i> Injur		Injury at Work?	i	.8d. Describe ho	w injury occurr	ed	
Division	or Attending after death. Director: After in by the fune	licat	2 Accident investig	not be One Diese of	Injury - At home, farm,		1 ☐ Yes 2		8f Location /St	reet and Numb	er or Rur	al Route Number.
<u>S</u>	in State	Cert	4 Homicide determ		etc. (Specify)	otreot, ractory, on	100		City or Town			ar riouta riomodi,
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical (29a. Certifier (Check only one) Certifyin	ng Physician: To the be Examiner: On the basis and manner	s of examination and/or	ath occurred at the investigation, in r	ne time, date my opinion, d	and place, a leath occurre	and due to the ca	use(s) and ma ate and place, a	nner as s and due t	stated. to the cause(s)
	To ti withi To ti comp	ž	29b. Signature and title of certifie			-	cense numbe		_	9d. Date signed	-	
			▶ Huchu	(Mmi)		D	3511	02		June 2	,	2007
	3		30. Name and address of person	who completed cause of			treet	BA	Himo	ve m	Aryl	land
	Sta		31. Date filed (Month, Day, Year)		strar's Signature	100					-	
	Registr	ar	JUN 2 6 20	07 Bour	, St. Age							

DHMH 17 Rev 1/2001

			State of Maryland / Dep		nd Mental Hyg	iene	20557
D			Registrar Ct	ertificate of Death		eg. No.	To The of Best
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Month	Day Year	3. Time of Death
	/Medic		Bernadine Pauline Mary Albre 4a. Facility Name (If not institution, give street and number)	4b. City. Town, or Location of	June	19 2007 4c. County of Death	0120 A M
1	Examin	er	412 North Street	E1kton	Death	Cecil	1
10.	Francis	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		4 Hrs. 8. Date of Birth	9 Birth	nplace (State or Foreign
	Funeral Director		219-07-8317 ^{1□ M 2} X F 86 Yrs.		Min. (Month, Day, FEB 26,	Year) Col	vland
Maria 1	distribution of		Usual Residence of Decedent		111111111	1721 1101	judila
	how at		10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	e Ma la-f s tified	cto	Maryland Cecil Elkton				1 X Yes 2 □ No
	ith th or 25 ie no	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	untry?
	ath w		412 North Street	21921		United St	
	er de	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer Black, White	
36	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notifiled at	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 M No If Yes, Give 3 M Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 X No Specify:		Specify: Wh	ite
215-0036	houn Itural	edk	11	edent's Usual Occupation		16b. Kind of Business/I	
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ğ	e filed within 72 h al Hygiene. I other than "natu vent, the Medica	BeC	17. Father's Name (First, Middle, Last)		s Name (First, Middle, i	Maiden Surname)	
/land		To E	Henry Kohlerman	Th	eresa Unkle	ebach	
Mar	2 sho and I is ma	i i	li i i i i i i i i i i i i i i i i i i	ling Address (Street and Number	or Rural Route Number	r, City or Town, State, Z	lip Code)
	and ealth m 27			North Street, E			
0	Pages 1 and 2 should thent of Health and Ment of Health and Ment int: If Item 27 is markee ary or other traumatice		20a. Method of Disposition 20b. Place of Disposition	position (Name of ematory or other place)	une 22,	20c. Location - City or	Town, State
altimore,	tmen tant: tant:	H	4 Donation 5 Other (Specify) Redeemer	ematory or other place) Holy Cemetery 20	007	Baltimore,	Marvland
g	permit. Pages Department of Important: If i any injury or once,		21. Signature of Funeral Service Licensee	22. Name and Address of Facility licks Home for F 03 W. Stockton	unerals, P	.A.	and 21921
*** ***			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one caus, on each line.				Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	bout Foul	110		Onset and Death
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	Examiner		Sequentially list conditions b. Atheroscotions	COVONALY MY	HIY DID	all	>5 yas
Ta	D +∺	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	05.			\
۶.	and I-trans	Examine	that initiated events resulting in death) Last Co. The last of th	- Wislase			13 years
8/60,	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	a E	230 to (0. 40 2 00.004201100 07)				
20	ficate physics the	edical	d				
XOX	nding use a	N.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy			23d. Date of deli	very
ň	death atte	Physician/Me	in the past 12 months? 1	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
j.	t the	hys	9 ☐ Unknown				
ν, Τ	requires that een signed b nould be deta	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ë	en sig	edk	Inemia, Perpheral Vascular L	rislase,	¹X/	es 2□No 3□Pro	obably 4 Unknown
Hecords	law re as be 2 sho	Completed	HTN		24a. Was a		topsy findings available
	sician: The law certificate has b	MO			perfor 1 Yes	med? death? 2 No 1 ☐ Yes	'
VITAI	ctor,	Be (25. Was case referred to medical examiner?	26. Place of	of Death (Check only or		
0	hysi this o	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati			ence 6 □Other (Spec	cify)
ğ	Attending Physician: r death. ector: After this certific. by the funeral director,	ion:	27. Manner of Death 1 Natural 5 □ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) Injury	Work?		ow injury occurred	
JIVISION	ttenc death stor: / the	icat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of injury. At home farm of	M 1 Yes 2 No		treet and Number or Ru	m/ Pouto Number
≧	after after I Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	troot, radiory, ombe	City or Town	n, State)	rai i iodie ivambei,
	pspitz hours unera y fille	alC	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and	place, and due to the c	ause(s) and manner as	stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	l edical	(Check only one) 22 Medical Examiner: On the basis of examination and/or and manner stated.				
	2 4 4 5	Σ	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Monti	1, vay, rear)
•			YIX/ V YAP	10003935	17 MD	une 19,0	1001
	10		30. Name and address of person who completed cause of death (Item 23a) (Type Renec Perkisms /// Litah St.	E/K 314 E/	Kton Mr.	21921	
	Sta	te	31. Date filed (Month, Day, Year) 39 Registraris Signature				
	Registr	ar	JUN 2 6 2007 June & Ap	eres.			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2007 **Physician** June 11, Manuel de Jesus Aquilar 5:10 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 517-77-4319 37 Aug 8, 1969 El Salvador Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Items 23a or 28a-f show iner must be notified at 1 XYes 2 No Maryland Prince George's Directo Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7975 Riggs Road, #4 20783 El Salvador Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Salvadorian 'natural", or Baltimore, Maryland 21215-0036 1. TYes 2□ No þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6th College (1-4or 5+) Landscaper Private and Mental Hygic Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Satulino Martinez Aurora Aguilar 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is Gloria Aguilar (Wife) 7975 Riggs Road #4, Hyattsville, MD 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 6/18/2007 Silver Spring, MD 21. Signatural Funeral Service License 22. Name end Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham MD 20706 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, let only one cause on each line. Approximate Interval Between Onset and Death art1. Enter the disease, shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Gastrointestinal Bleeding **Physician** /Medical Due to (or as a consequence of): Examiner Thrombocytopenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Coagulopathy Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Alcoholic Hepatitis 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed Alcoholism 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 22 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of confifier M.D D0059121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tasneem Malik, M.D. 7600 Carroll Avenue, Takoma Park, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 2 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

			Please Type or Print in Black In			-		_	e.	
			1- State Registrar Amend #788 Per FH G868 6/26/0			-	Reg. No		7 7	7 7 7
100	Physici	an	Decedent's Name (First, Middle, Last)		_	2. Date of D	eath Da	ay Y	3. Time of ear	Death
	/Medic	al	Manuel de Jesus	_	Arguera	Vune			77 116	m
) 	Examin	er	4a. Facility Name (If not institution, give street and number) Doctor's Community Hospital		4b. City, Town, or Location of Deat Lanham If Under 1 Year If Under 24 Hrs		p	c. County of Prince	Geoma's	766
l	Funeral Director		5. Social Security Number 218-08-0572 6. Sex 12M 2 F 7. Age (In yrs. last birthda, 54 55 Yrs.	<i>y)</i> _	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	March	rth 22 <i>,</i>	,1952° 1953	Birthplace (State of Country) EI Salvac	or Foreign dor
	/land low at		10a. State 10b. County 10c. City, Town or	Loca	ation				10d. Inside Ci	ty Limits
	a-f sh	ctor	Maryland Prince George's		Lanham				1 ₹ Yes	2□No
	ith the	Directo	10e. Street and Number		10f. Zip Code			itizen of Wha	•	
	s 23a	eral	9951 Elm Street		20706			l Salv		
	fter de r item iner r	Funeral	1 ☐ Never Married 2 ⚠ Married 1 ☐ Yes 2 ☒No		as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	0-		American Indian, White, etc.	
Š	ours a ral', o Exam	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 1	Yes 2□ No <i>Specify:</i> Sa	lvadori	an	Specify:	Hispanio	C
2-0036	72 hc "natu	etec	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	ede ve ki	ent's Usual Occupation ind of work done during most of wo O NOT use retired)	rking	16b. l	Kind of Busir	ess/Industry	
72	within ene. than he Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		onstruction Work			Priva	ate	
מַ	e filed al Hygi other /ent, t	Be C	17. Fatteris Name (First, Middle, Last) Fatteris Name (First, Middle, Last) Fatteriandez		18. Mother's Nar		e, Maide			
<u>Ya</u>	2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	To E	Eduriges Hernandez			nta Argi				
w	_ g s =				Address (Street and Number or Ri 1 Elm Street, La				ate, Zip Code)	
คั	es 1 and 2 of Health item 27 i		20a. Method of Disposition 20b. Place of Disposition		ition (Name of atory or other place)	Date	,		y or Town, State	
aitimore,	Page nent o		A Dunal 2 Licientation 3 Linemoval from State 1			/2007	Si	lver S	Spring, M)
gall	permit. Pages 1 Department of H Important; If ite any Injury or ot once.	H	21. Signa no of Funeral Service Lice see		Name and Address of Facility					
	<u> </u>	///	23 Part Spring the disease or complications that caused the death. Do not a		013 Annapolis Ro			MD 20		
	Physician		23a Part1. Enter the dise section of complications that caused the death. Do not e shock, or heart failing. List only one cause on each line.				arrest,		Approximate Interval Bety Onset and D	ween
	Physician /Medical		disease or condition resulting in death) a. SEVEC Due to (or as a consequence of):		RHCYTOP E		_		_	
	Examiner		Sociantiativites conditions h. A cutie of		CHROMIC R	EnPAL	20	TILUZ	۵	
	ted sit	xamine	Soquer daily list contribute if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
,	executed in and ial-transit	Exar	that initiated events resulting in death) Last C. Due to (or as a consequence of):							
08/PN	w requires that the death certificate be e been signed by the attending physician should be detached for use as the burie	<u>ca</u>	d							
	ertifica ding ph	Med	IF FEMALE:							
X D D	attend	cian	in the past 12 months?		Ectopic pregnancy Other (specify)			23d. Date o Month		/ear
	requires that the death een signed by the atter nould be detached for u	Physician/Medi	1 ☐ Yes 2 Not 9 ☐ Unknown							
S,	es tha igned be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	und	derlying cause given in Part I.	23e. Did			te to the cause of de	
ecords	requii	Completed	DIABETES MELL		- · · ·	1	Yes 2	2□ No 3[Probably 4 🖳	hknown
ב ב	238	mple	DIMPH & MEET		703,	24a. Was		24b. Wei prio dea	re autopsy findings a r to completion of ca	available ause of
VII.	sician: The law certificate has t irector, page 2 s		25. Was case referred to medical		OC Plans of De-	1□ Yes	2 D M		Yes 2 □ No	
5	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 ☐ Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient	ent	26. Place of Dea	lome 5 ☐ Res		6 ∏Other /	Specify)	
10 U	ng Ph After th		27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time (Month, Day Year) 27. Injury (Month, Day Year)		28c. Injury at Work?	28d. Describe				
UNISION	ttendi Jeath. stor: A	catio	2 Accident investigation		M 1 ☐ Yes 2 ☐ No	001 1 1	·-·			
<u> </u>	al or A	Certification:	3 Suicide 4 Homicide determined 28e. Place of injury - At home, farm, s building, etc. (Specify)	stree	ет, тастогу, опісе	28t. Location (City or To	Street a wn, Stat	nd Number (te)	or Rural Route Numi	ber,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 1	ath o	occurred at the time, date and place estigation, in my opinion, death occu	e, and due to the urred at the time	cause(s , date ar	s) and manne nd place, and	er as stated. I due to the cause(s))
	To th Within To th comp	Me	29b. Signature and title of certified		29c. License number		29d. Da	ate signed (A	Month, Day, Year)	
	(2)				767810)	6	111/2	7.	
-	(1)		30. Name and address of person who completed cause of death (Item 23a) (Type	e, Pr	rint)	O 1 - 144	`\	7.7	01	
	Sta	te	Azez A. Abiodun 818 Good Lu 31. Date filed (Month, Day, Year) JUN 1 2 2007 Superior Day, Year) JUN 1 2 2007	LC.	rka, coun	um, m	D,	207	V (p	
	Registra		JUN 1 2 2007 Back D. Spiele	/						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Midelle, Last) Month Year **Physician** 6:00 pm Raina /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Garrett 422 Underwood Rd. Oakland | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) | April 17,1936 | West Virginia If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days Months 1 ☐ M 2**X** F Yrs. Director 232-56-9549 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2X No Director Oakland Garrett 10g. Citizen of What Country? 10f Zin Code 10e Street and Number 5 21550 USA 422 Underwood Rd. Items 23e Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc. ☐Yes 2 No 1 Never Married 2 Married Saltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify. Specify: White If Yes, Give Completed by 3 Widowed 4 XDivorced neturel 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Coal Miner Coal 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be finent of Health and Mental Hint: If item 27 Is marked of Nellie McKinney Hedrick B. Artis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 422 Underwood Rd., Oakland, MD J.B. Chambers/Son other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🗖 Cremation 3 ☐ Removal from State ō Department of Importent; If any injury or once. Country Side Crematory June 18, 2007 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signatura of Funeral Service Licen P.O. Box 275, Grantsville, MD_ Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) months **Physician** hroat ancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, passage or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months?

1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 2 No 1 Yes 2 No 1 Yes Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the the within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8 plame and address of pers in who completed cause of death (Item 23a) (Type, Print Oakland, Md 21550 MD segistrar's Signature 31. Date filed (Month, Day, Year) State 20 2007 Registrar

			State of Maryland /	Departme		Mental Hyg	iene	20561
			Registrar 1. Decedent's Name (First, Middle, Last)	OUTITIOE	ale of Beatif	2. Date of Deat		3. Time of Death
	Physicia	_	BENONI DAWSON ALLNUTT			JUNE	12° 20°7	8:55 A ^M
,	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. C	ity, Town, or Location of De	ath	4c. County of Dea	ith
			NIGHTINGALE HOUSE		AITHERSBUR		MONTGO	
	Funeral		5. Social Security Number 6. Sexy 7. Age (In yrs. last b	Yrs. If Uni	der 1 Year If Under 24 H hs Days Hours M	rs. 8. Date of Birth (Month, Day, APR 22	Year) 9. Bi	thplace (State or Foreign ountry) MD
	Director		213-38-4371 Paw 207 90 Usual Residence of Decedent			AIN ZZ		1110
	how			own or Location	-			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	8a-f	Director		THERSBU			0.000	
	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ehow I.a Medical Examinar must be notified at	ai Dire	10e. Street and Number 217 BOOTH ST., #208A	107.	Zip Code 20878		0g. Citizen of What C	SA
	r dea	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was De If Yes, s	cedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - Am Black, Wh	
36	s afte	by Fi	1 ☐ Never Married 2 1	1 🗆 Yes	s 2 No Specify:		Specify: W	HITE
8	2 hour	ed t	15. Decedent's Education 16	3a. Decedent's U	Isual Occupation		16b. Kind of Busines	s/Industry
215	hin 73	pie	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of life, DO NO	work done during most of v T use retired)	vorking	AGRICULT	ממוזו
2	filed will Hygien other the	Completed	12	FARMER				ORE
/land	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene them 23s or 28s-1 show them 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, I'm Medical Examinar must be notified at	To Be	17. Father's Name (First, Middle, Last) ROBERT WILKERSON ALLNUTT		MARY	lame (First, Middle, I	IOMAS	
Mar	ind 2 sho aith and 27 is ma				ess (Street and Number or)TH ST., #2			
Baltimore, Maryland 21215-0036	permit, Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		cemei	of Disposition (intery, crematory of FFER CF	Name of or other place) REMATORY 6/		20c. Location - City o FREDERIC	
Baltii	permit, I Departm Importar any injur		21. Signature of Funeral Solvi & Licensee	22. Name H T L T	and Address of Facility	HOME	TE MD	20838
			23a. Part 1. Enter the disease, or complications that caused the death. Dishock, or hear failure. List only one cause on each line.	o not enter the n	BOX 86, P	liac or respiratory arr	est,	Approximate Interval Between
	Physician	7	Immediate Cause (Final disease or condition a CORONARY AR'	TERV D	TSEASE			Onset and Death
	/Medical		resulting in death) a					
	Examiner	_	Sequentially list conditions, b. Due to for as a consequence	on offi				
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	o orj.				
,	te be executed ysicien and ie burial-transit	Examiner	that initiated events c	e of):				
_	ysicie	cai	d.					
9	ng ph	Medi	IF FEMALE:					1000
Box	leath certificate attending phys i for use as the	Physician/Medi	23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea	ath 3 ⊟Ectopi	c pregnancy		23d. Date of d	elivery Day Year
0. 0.	he de the a	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	ı 5 ☐ Other	(specify)			
	The law requires that the death certificat sie has been signed by the attending phy agge 2 should be deteched for use as th	þ	Part II. Other significant conditions contributing to death but not resulting CEREBROVASCULAR DISEASE	g in the underlyin	ng cause given in Part I.		bacco use contribute	to the cause of death?
Ö	w requir been si should	Completed				24a. Was a		- //
Rec	has i	ш				- autops perfor	med?/ death?	
a	ifficete or, pa	e Co	25. Was case referred to medical		26 Place of I	1 ☐ Yes Death (Check only or		s 2 No
>	Attending Physician: r death. ector: After this certificator, by the funeral director, i	ToB	examiner?	Outpatient 3	04		ence 6 ☐Other (Sp	ecity)
0	ng Ph Iter th neral		27. Mann of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year)	b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	
Sio	eath. or: Al	catic	2 Accident investigation	М	1 ☐ Yes 2 ☐ No			
Division of Vital Records,	s efter d	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, fac	ctory, office	28f. Location (S City or Town	treet and Number or I n, State)	Rural Houte Number,
	To the Hospital or Attending Physician: The I within 24 hours eiter death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	edicai	29a. Certifier (Check ofly one) 1 Cartifying Physician: To the best of my knowled 2 Madical Examiner: On the basis of examination and manner stated.					
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier		29c. License number D0064615		9d. Date signed (Mo.	nth, Day, Year)
)	0		Shanne Whole mi	>			6/13/07	
	7		30. Nanie and address of person who completed cause of death (Item 23		CCARD DR.,	DOCKUTT	TE MD 2	0.850
	Sta	ate.				VOCT A TT	nn, mu Z	
	Registi		31- Date filed (Month, Day, Year) 32. P. Jistrar's Signature	* Span	K			

Gary Joseph	Boynton
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		1- For State Registrar	rtificate of Death	Reg.	. No.	1 1100
Physic		Decedent's Name (First, Middle,Last)		2. Date of Death Month	Day Year	3. Time of Death
ledical Exam	niner	GARY JOSEPH BOYNTON		June 18, 20	07	1751 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	1
		Upper Chesapeake Medical Center	Bel Air		Harford	
Funera		5. Social Security Number 6. Sex 7. Age (In yrs.			(MM/DD/YYYY) 9. Bir Foreig	
Directo	r	217-94-8699 X M 2 F 28	Yrs. Months Days Hours Min	03/12/	1979 Co	untry) MD
		Usual Residence of Decedent				
any		10a. State 10b. County 10c. City	, Town or Location			10d. Inside City Limits
* .	_	PA York Fa	wn Grove			1 Yes 2 X No
Maryland 28a-f show 4 at once.	용	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?
or 28	Director	277 Ridge Road	17321		USA	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	erall	11. Marital Status 12. Was Decedent Ever in U	J.S. 13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-		ican Indian, Black,
ath v item:	lue!	1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto		White, etc.	
ter de	1 4	1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify:	White
urs af	by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of	work done	16b. Kind of Business/	Industry
2 hou "mail	tec	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret	tired)		
.0036 within 72 giene. her than "	힐	12	Heavy Equip. Operator		Manufactu	ring
5-0036 led within 72 hours Hygiene. other than "natur the Medical Exam	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Ma	aiden Surname)	
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. Mental Hygiene. The Medical Examiner must be notified at once	Be (Gary M. Boynton	Kath1	een M. Ka	arl	
213	2	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or	Rural Route Numb	er, City or Town, State	e, Zip Code)
MD d 2 shc lth and n 27 is		Kathleen M. Boynton/Mother	277 Ridge Road, Fawn	Grove, 1	PA 17321	1
		20a. Method of Disposition 20b	. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or	Town, State
Baltimore, permit. Pages I an Department of He Important. If ite		1 Burial 2 X Cremation 3 Removal from State	ans Eagle Crematory 6/2	2/2007	Leola, PA	
Iting Program	5	4 Donation 5 Other Specify: 21 Judge of Funeral Sewipe Licensee	22. Name and Address of Facility	2,200,	Beeta, 111	
Balt permit. Departi Importi	-	Allen Physical	Harkins Funeral Ho	me. Tric.	. Delta. P	A 17314
Physicia		23a. Part I. Enter the disease, or complications that caused the deat				Approximate Interval
/Medica		/ failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries				Between Onset and Death
Examine	r	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence	of):			-
		h				
	je je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence	of):	11 1		
_	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence	-6			-
Way 2		events resulting in death) Last Due to (or as a consequence	or).			
c68760, certificate be executed ending physician and see the hurial a transit	Medical	UNPENDED AMENDED				
760, cate be ex physician	edi				23d. Date of deliver	1
376 ificat		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pre	gnancy 2 Fetal death 3 Ectopic pregr	nancy		Day Year
ox 68 ath certif	cian	past 12 months?				
Box e death c	Physician	1 Yes 2 No 9 Unknown g Unknown				
that the death		Part II. Other significant conditions contributing to death but not	resulting in the underlying cause given in Part I.		acco use contribute to	
, P.(res that signed				1 Yes	2 V No 3 Pro	bably 4 Unknown
ords, w requir	Completed			24a. Was at autops		utopsy findings available completion of cause of
COI e law				perform	ned? death?	_
tal Rection: The certificate	Sol	OF Management and the state of	26.Place of Death (Check	1 Yes 2	No 1 ✓ Y	es 2 No
of Vital Records, P.O. ne Physician: The law requires that it is the this certificate has been signed by the deed by the confinence of the deed by the	Be (25. Was case referred to medical examiner?	- Others		Residence 6 Othe	er:
f Vi Physic er this	E -	1 Yes 2 No Impatient 2 S	28b. Time of Injury 28c. Injury at Work?		ow injury occurred	
n of	ation: T	1 Natural 5 Pending Jun 18, 2007	1621 hrs 1 Yes 2 No		cycle auto collision	on
Sio		2 Accident Investigation	home, farm, street, factory, office building, etc.	28f Location (St	treet and Number of P	tural Route Number, City
Division spital or Attendis cours after death reral Director: A	Certification:	Suicide 6 Could not be		or Town, St		ara Rode Namber, Only
		4 Homicide		1		ited
	edical	(Check only one) 2 Certifying Physician: To the best of my knowled one) 2 Medical Examiner: On the basis of examination	edge, death occurred at the time, date and place, an and/or investigation, in my opinion, death occurred	at the time, date a	no, and manner as stained place, and due to t	he cause(s)
To the within To the	Medical	and manner stated. 29b. Signature and title of certifier	29c, License number		29d. Date signed (Me	
	2	250. Signature with the or certainer	O.C.M.E.		June 19, 2007	
		Muna Grasse 4 My				
П		30. Name and address of person who completed cause of death (Ite		21201		
		Melissa Brassell, MD Assistant Medical Exam	iner 111 Penn Street, Baltimore, MD	/ Z Z U		
		31. Date filed (Month, Day, Year) 32. Registrar's Signa	thurs distribution			

State of Maryland / Department of Health and Mental Hygiene 2 [] [] 7

			State Registrar					Cer	tificat	e of L	Death			Reg. No		146 8	Eur Tari Ton	
7	Dhysisia		1. Decedent's Name (First, Mi			Don	+holo	morri.					2. Date of De _Month		У	Year	3. Time of	
	Physicia /Medic		Margaret	V 1	rginia	Daı	CHOTO	mew					June 1		ž007		9:15	Ам
¥	Examin	er	4a. Facility Name (If not Institution 1091 Carson	_		ımber)			4b. City,		Location			4c.		of Death alver	+	
			5. Social Security Number	6. S		7 Age /	(In yrs. last t	hirthday)	If Under		If Under		8 Date of Bir	th	_			r Foreian
	Funeral Director		579-03-5339 Usual Residence of Decedent			7. Age (88	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Nev 4,	y, Year) 191	L8	Was	lace (State of try) h. D.C	·
	/land ow at		10a. State 10b. Cou	nty		1	10c. City, To	wn or Lo	cation							1	0d. Inside Cit	y Limits
	a-f sh	ctor	MD Pri	nce	George	s	Uppe	r Ma	r1bor	O							1 ☐ Yes	2 X No
	or 28	Director	10e. Street and Number						10f. Zip					10g. Cit		What Coun	itry?	
	ath w		9109 Goldenr	od L		=		140.			772	1.0.0				SA e - Americ	on Indian	
	er de items ner n	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ M	larriad	12. Was Dec	orces?		13.	was Deced If Yes, spe	cify Cuba	spanic Or n, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	-		ck, White,	etc.	
2	ırs aft	by F	3 ☑ Widowed 4 □ Divore		If Yes, G Year or I	2 √∑ No ive ⊃ates:			1 🗌 Yes	2X No	Specify:				Specif	y:	Whit	е
5	be filed within 72 hours after death with the Maryland Hygiene. A thygiene. do ther than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted	15. Dece (Specify only hig	lent's Ed	ducation ade completed)	16	a. Dece	dent's Usua	al Occupa	ation	t of work	ina	16b. K	and of B	usiness/Ind	dustry	
į	ithin Je.	Completed	Elementary/Secondary (0-1		· · · · · · · · · · · · · · · · · · ·	(1-4or 5+)			kind of wo DO NOT us				g	~			/C ·	
7	lled w Hygiel Hertl nt, th		12 17. Father's Name (<i>First, Mide</i>	lle I ast)			Cter	ical-	Secr			e (First, Middle				/Scien	ce
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<u> </u>	2 should and Mer is marke aumatic	욘	19a. Informant's Name/Relati	onship (Type. Print)		1:			(Street a	and Numb		al Route Numb	er, City o	or Town,		<u> </u>	
Ĭ	and 2 ealth a n 27 is ner tra		Patricia Kro	sel	(niece)		1091	Cars	on I	rive	Hu	ntingto	wn,	MD	2063	9	
5	of He of He or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	n 3.F	Removal fron	ı State	20b. Place ceme	of Dispo tery, crei	sition (Nar matory or c	ne of ther plac	e)		Date	20c. L	ocation	- City or To	own, State	
	. Pages tment of I tant: If its jury or o		4 Donation 5 ☐ Othe	(Specil	y)		Ft. L						14 2007			wood,		
ם כ	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once.		21. Signature of Funeral Serv	~	1see								e Funer and Blv					A 73 6
			23a. Pan1. Enter the disease	or of	plications that	caused th	he death. D					-			OWI	ugs,	Approximate	
y	Physician		shock, or heart failure. Immediate Cause (Final	_ist only	one cause on	each line	mi	hi									Interval Bet Onset and I	veen Death
	/Medical		disease or condition resulting in death)	•	a. Due to	or as a	consequence	e of):)	-								
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5	rtificat ng phy as th	Medical	IS FEMALE.														=0	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	10		birth 2 gnant at ti	f pregnancy Detal dea ime of death		⊒Ectopic p ⊒ Other <i>(s</i>							ate of delive onth	-	/ear
	that thed by the		9 ☐ Unknown Part II. Other significant con	ditions	contributing to	death but	not resulting	g in the u	nderlying o	ause give	en in Part	I.	23e. Did	tobacco	use con	tribute to the	he cause of d	eath?
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5	Phys r this eral dir	-: To	1 Yes 2 → 10	-	28a. Date	e of Injury		b. Time o		28c. Injur Worl	7011	ursing H	ome 5 ☐ Res 28d. Describe				Resid	dence
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2	r Atte er dea recto by th	Certification:	3 ☐ Suicide 6 ☐ Co	uld not b ermined	200. Fide	ce of injury	y - At home, (Specify)	farm, sti	reet, factor	y, office			28f. Location (Street a	nd Num	ber or Run	al Route Num	ber,
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	Sta Registr		31. Date filed (Month, Day, Y JUN 13 200		32.	_	's Signature											

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Leonille D. Blair June 11 2007 8:05A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Union Hospital Elkton If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F 99 Yrs. Director Sept. 28, 1907 Massachusetts 031-30-3114 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "naturel", or Items 23a or 28a-f show If e Would Examiner must be notified at 1 Yes 2X No Director Maryland Cecil E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1235 Elk Forest Road 21921 United States death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 is marked other than "naturel", or Ite 1 XYes 2 No If Yes, Give World War 1 Yes 2 XNo Year or Dates: 1 Never Married 2 Married Baltimore. Maryland 21215-0036 Specify: White Specify. þ 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Air Force 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William DuFault Noelia Allaire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oakley B. Blair/son 811 Catoctin Circle, NE, Leesburg, VA 20176 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 StBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. `4 □Donation 5 □Other (Specify)

21. Sign 11 of uneral Service bicens 06-15-2007 Brockton, MA Calvary Cemetery 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 318 George St., Chesapeake City, MD 21915 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician)105ep515 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Dav Year 5 ☐ Other (specify) 4□Pregnant at time of death the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 2X No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an Hea 2 **X**No Strue 1 ☐ Yes as case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28c, Injury at Work? 27. Manner of Jeath ate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred e Hospital or Attending Pl 24 hours after death. a Funaral Diractor: After t 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifies Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature at s fors of completed cause of death (Item 23a) (Type, Print) 12+1VA John R. Mulvey M.D., 111 West High Street, Suite 309, Elkton, MD 21921 31. Date filed (Month, Day, Year) State JUN 1 2 2007 Registrar

DHMH 17 Rev 1/2001

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			For State Registrar		State of	Maryland		artment of rtificate of		and M	-	giene, Reg. No.	200	7 20555
	Physici		1. Decedent's Name William	,	Last) Lsworth	Baker					2. Date of Dea Month June 1	Day	Year	3. Time of Death 10:30 A M
	/Medio Examin		4a. Facility Name (If	not institution,	give street and numb	oer)	1	4b. City, Town,		of Death		4c. C	County of Dea	
	Funeral Director		5. Social Security No. 233–62–77	umber 6		Age (In yrs. las			r If Under:	24 Hrs. Min.	8. Date of Birt Month, Da 10/14/	h	9. Bir	thplace (State or Foreign ountry) t Virginia
	ס		Usual Residence of 10a. State	Decedent 10b. County		10c. City, 1	own or Lo	ocation						10d. Inside City Limits
	Mary B-f eh	tor	WV	Prest	on	Aur	ora							1 ☐ Yes 21 No
	or 28	Jirec	10e. Street and Nun	nber				10f. Zip Code				10g. Citiz	en of What C	ountry?
	ath wi	rai	Rt 1 Box	360					705			US		
36	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. any niury or other traumatic event, the Madical Examinar must be notified at Opper.	by Funeral Director	11. Marital Status 1 □ Never Marrid 3 □ Widowed		12. Was Decede Armed Force d 1 Ves 2 If Yes, Give Year or Date	^{es?} □ ^{No} 1958∙		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No	ban, Mexican	gin? (Spe i, Puerto l	ecify Yes or No Rican, etc.)		Black, Whi	erican Indian, te, elc. nite
21215-0036	in 72 hou n natura Medical E	Completed	(Speci	, , ,	Education grade completed)	1500	(Give	dent's Usual Occi kind of work don DO NOT use retii	e <i>durina</i> most	t of worki	ng	16b. Kin	d of Business	
1212	iled with Hygiene ther the nt, the		12 17. Father's Name (College (1-4	or 5+)	Сс	al Mine		r's Nama	(First, Middle,		oal Min	ning
Maryland	ould be f Mental H mrkad of	To Be	William	F1e	eming	Baker			Maxi	ne	Stel	1a	Shaf	
, Mar	and 2 sh alth and 27 ie m er traum		19a. Informant's Na Ellen B.					ng Address (Street 1 Box 3)				. ,	Town, State,	Zip Code)
Baltimore,	Pages 1 of He nt: If item ry or oth		20a. Method of Disp 1 ☐ Burial 2 £ 4 ☐ Donation	Cremation 3	Removal from Sta	ate cem	etery, crei	esition (Name of matory or other pi		ء (6/19	/07		ation - City of	
Balti	permit. Deportmitmporta any niu		21. Signature of Fur	neral/Service Li	pensée .		22	2. Name and Add	ress of Facilit	y Ste	ewart F	unera	al Home	
	Physician		23a. Part1. Enter Ih shock, or hear Immediate Cause (disease or condition resulting in death)	t failure. List or Final	a	atic Lu	ng Ca	er the mode of dy					21330	Approximate Interval Belween Onset and Death Years
	/Medical Examiner			SERVICE		as a consequer atic Co		Cancer						Years
	uted d ansit	Examiner	if any, leading to im cause. Enter Under Cause (Disease or that initiated events	njury T		as a consequer								***************************************
68760,	icate be executed physicien and s the burial-transit	dicai Exa	resulting in death) L		Due to (or	as a consequer	ice of):							
	law requires that the death certific as been signed by the attending pl 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?		h 2 ☐ Fetal de it at time of deat	ath 3	Ectopic pregnan Other (specify)	су			23	3d. Date of de Month	olivery Day Year
rds, P	w requires thet been signed b should be deta	ě	Part II. Other signifi	cant condition	s contributing to deal	lh bul not resullir	ng in the u	nderlying cause g	iven in Part I.			bacco us		o the cause of death?
0	The law re ate has bee page 2 sho	Completed									24a. Was autop perfo 1 Yes		prior to death?	utopsy findings available completion of cause of
/ita	clan: ertific actor,	Be	25. Was case referr examiner?	ed to medical		_				of Death	(Check only o			
of Vital	Physician: rthis certifici ral director,	2		No .	Hospital: 1 Inp		/Outpatier	IT 3 DOA			ne 5 Resid			ecify)
	ding h. After funer	tlon	1 hatural	5 Pending Investiga	28a. Date of (Month,	Day Year)	b. Time o Injury	W	uryat ork? ∫Yes 2.⊟≀	_	28d. Describe h	iow injury	occurred	
Division	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	Accident Suicide Homicide	6 Could no determin	t be 28e. Place of	Injury - At home , elc. (Specify)	, farm, str	eet, factory, office			28f. Location (S City or Tox		Number or F	tural Route Number,
	Hospita 24 hours Funeral stely filled	edical C	29a. Certifier (Check only one)	1 Certifying	Physicien: To the board and manner	is of examination	dge, deat and/or in	n occurred at the vestigation, in my	time, date and opinion, deat	d place, a	and due to the e	cause(s) a date and p	and manner a place, and du	s stated. e to the cause(s)
	To the	X e	29b. Signature and	title of certifier	1			29c. Licer	nse number			29d. Date	signed (Mon	th, Day, Year)
)	12		•	til				1	15	33	3	(a 15	(0)
7	LIVA		Dw Thon	200 C	o completed cause			Print) Fourt	n S+	Oale	land M	n 215	550	
	Sta Registr		31. Date filed (Mont	JUN Z'O	100	jistrar's Signatur		. Fourt	1 06.9	vak.	Lanu, M	<i>J</i> 213	,,,,,	

Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.
1	Physician
1	Physician /Medical Examiner
Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Funeral Director

1	For State Registrar	•	nt of Health and M te of Death	ientai Hygiene Reg. No	0 . 1 7 7	20567
ysician	1. Decedent's Name (First, Middle, Last) Frank Paul	Bonomo		2. Date of Death Month Da	ay Year 07	3. Time of Death 0428 A M
diffine	4a. Facility Name (If not institution, give street and number) ENINSULA KEGIWAL MEDICAL 5. Social Security Number 6. Sex 7. Age (In yrs	ENTER S Last birthday) If Und	y, Town, or Location of Death ALISBURY er 1 Year If Under 24 Hrs.		County of Death Ocames 9. Birthpl	ace (State or Foreign
ctor	079-36-4714 11√ M 2 F 62 Usual Residence of Decedent	Yrs. Month	s Days Hours Min.	3/25/1945	New	York
be notified at Director	Maryland Worcester Oc	cean City	Pio Codo	10a C	itizen of What Coun	Od. Inside City Limits 1 XYes 2 No
eral Dire	10e. Street and Number 43505 70th Street 11. Markel Status 12. Was Decedent Ever in 1		Zip Code 21842 redent of Hispanic Origin? (Sp		USA 14. Race - America	
by Fur	11. Marital Status 1 ☑ Never Married 2 ☐ Married 1 ☑ Ves 2 ☑ No If Yes, Give Year or Dates:	If Yes, s _i	pecify Cuban, Mexican, Puerto 2☐ xN o <i>Specify:</i>	Rican, etc.)		ite
t, the Medical E Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4	16a. Decedent's Use (Give kind of life. DO NOT	work done during most of work use retired)	ding	Kind of Business/Inc	_
atic event, the To Be Co	17. Father's Name (First, Middle, Last) Nicholas A. Bonomo	CHEMILE		e (First, Middle, Maide		
er traumat	19a. Informant's Name/Relationship (Type. Print) Emanuel Bonomo/brother	109 Hawt	ess (Street and Number or Rui Chorne Court W	est, Hocke	ssin, DE	19707
ury or othe	1 Burial 2 Cremation 3 Removal from State	Place of Disposition (N cemetery, crematory of Nashington Park	Memorial 6/16	6/07 Co	Location - City or To	
any In	21 Sq. min Fluneral Service Licensee CF. 23a. Part1. Enter the disease, or complications that caused the de-	SP 501	and Address of Facility Loway Funeral Snow Hill Rd.	<u>, Salisbur</u>	ssional A y, MD 218	ssociation 04 Approximate
the burial-transit and leading	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a. Due to (or as a conse	equence of):				
Out the Fundant Director, Angel has obtained as thought of the description of the fundant of the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnant at time of 9 □ Unknown	etal death 3 □Ectopi	c pregnancy (specify)		23d. Dete of deliver Month	ery Day Year
uld be detac	Part II. Other significant conditions contributing to death but not re	resulting in the underlyin	g cause given in Part I.		o use contribute to t	1/
page 2 should				24a. Was an autopsy performed 1□ Yes 2	prior to co	opsy findings availat mpletion of cause o 2□ No
If director,			DOA Other: 4 Nursing H	ath Check onl one lome 5 ☐ Residence		fy)
led in by the funera	27. Manner of Death 1	t home, farm, street, fac	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in 28f. Location (Street City or Town, St	and Number or Rur	al Route Number,
pletely filled in edical Cert	29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my in the best	knowledge, death occur	red at the time, date and place tition, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
Scomple	29b. Signature and title of certifier		29c. License number 0 4 6 5 3 6	29d.	Date signed (Month)	Day, Year)
3	30. Name and eddress of person was completed cause of death (I	Item 23a) (Type, Print)	shung MD Z	180'DR.WEH	BERG	
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature Signa		,			

Regis DHMH 17 Rev 1/2001

	1 - For State Registrar		of Maryland	•	rtificate of			, 0	g. No. 🤈	nat	1 2056
	1. Decedent's Name (First, I	Middle, Last)					2	2. Date of Death Month	Day	Year	3. Time of Death
an cal	James	L.	Bowde	en				JUNE	3	2007	1444
er	4a. Facility Name (If not insti	tution, give street and nu	()		4b. City, Town, o				2 1	ty of Death	
		BIANAL 1/EDI				SBUR	*		Wic	omic	50
	5. Social Security Number 214–34–6153 Usual Residence of Deceder	6. Sex 1 ∑ M 2 ☐ F	7. Age (In yrs. last	Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day,) 8/22/193	,	Cot	nplace (State or Foreiguntry) ryland
ctor	10a. State 10b. Co		10c. City, T	own or Lo							10d. Inside City Limit
al Director	10e. Street and Number 1033 Zircon	Court		21804					0g. Citizen of What Country? USA		
by Funeral	11. Marital Status 1 □ Never Married 2 仅 3 □ Widowed 4 □ Divo	Armed Formal 1 ☐ Yes Gi	2 Mo ve No		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexicar	n, Puerto Ri	ify Yes or No- ican, etc.)		ack, White	ncan Indian, e, etc. ite
Completed	15. Dec (Specify only h Elementary/Secondary (0-	edent's Education highest grade completed)	1	(Give	dent's Usual Occup kind of work done DO NOT use retire	durina mos	at of working	9	 6b. Kind of E		
Š	12	-		Bar	ber				Hair (Care	
Be	17. Father's Name (First, Mic	. ,				18. Mothe	er's Name (First, Middle, Ma	aiden Surna	ame)	
P	William Clif	ton Bowden				Man	nie Sm	nack			
	19a. Informant's Name/Rela Elizabeth Bo				ng Address (Street 3 Zircon						lip Code)
	20a. Method of Disposition	tion 3 □Removal from	l com	e of Dispo etery, crei	osition (Name of matory or other pla	ice)	Da	te 20	Oc. Location	- City or	Town, State
	4 Donation 5 Oth		1	rk C	emetery		6/12/	′07	Newa	rk, M	1D
	21. Signature of Funeral Se	rvice Licensee		22	2 Name and Addre	E 112					
	23a. Part1. Enter the disease shock or heart failure	se, or complication at a	caused the death. I	_ :	SOI Snow	HITT	Rd.,	Salisbu	ry, M	nal A D 218	Approximate
dical Examiner	23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aDue toDue to	caused the death. Deach line. (or as a consequent (or as a consequ	Do not ent	SOI Snow	HITT	Rd.,	Salisbu	ry, M	nal A D 218	304
sician/Medical E	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a	(or as a consequen (or as a consequen (or as a consequen titcome pf pregnancy birth 2 Fetal de nant at time of deat	Do not ent PS / S noe of): noe of): noe of):	SOI Snow	H111	Rd.,	Salisbu	23d. D	nal AD 218	Approximate Interval Between Onset and Death DAYS
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by Physician/Medical E	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 2 yes 2 No 9 Unknown Part II. Other significant co	a	(or as a consequen (or as a consequen (or as a consequen toome pf pregnancy birth 2 ☐ Fetal de nant at time of deatl iown leath but not resultin	Do not entered of the control of the	ter the mode of dyi	H111	Rd., cardiac or	23e. Did toba 1 Yes 24a. Was an autopsy perforque	23d. D	D 218	Approximate Interval Between Onset and Death Death Onset and D
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State Registrar

JUN 1 2 2007

State of Maryland / Department of Health and Mental Hygiene 1- State 6/13/07 Amend 29c eks Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 9, 2007 Year **Physician** Max Rudolph Bluntschli 6:45 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Candle Light Cove, 106 W Earle Ave. Easton Talbot B. Date of Birth (Month, Day, Year)
June 19, 1924

9. Birthplace (State or F. Country)
Switzerland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 1 M 2 □ F 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 158.18.8873 82 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits or iteme 23a or 28a-f ehov the Medical Examiner must be notified at 1 X Yes 2 □ No Directo Talbot St. Michaels Maryland 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? USA 9767 Martingham Circle 21663 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: þ 3 XWidowed 4 ☐ Divorced White 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygier importent: if item 27 is marked other th any injury or other traumatic event, the once. Professional Engineer 12 Chemical Engineering 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (Walter Bluntschli Irene Laubi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter J. Bluntschli/Son P.O. Box 34, Short Hills, NJ 07078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State MidShoreCremationCenter 6/11/2007 Cambridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 27. Signature of Funeral Service Licensee Mid Shore Cremation Center, P.O. Box 1464, Delease Therefore, Lawrence Lower Lower Lawrence (Cambridge, 2 Fart). Enter the disease or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart the first List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ARTERIOSCEROTIC CARDIOVASCULAR DISEASE **Physician** /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificete be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy hed by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PARKINSON'S DISEASE. 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No 24a. Was an rmed? 2 No this certificate 1 ☐ Yes tor: After this certific the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ZNo ဥ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No efter death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 T Homicide within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ^{29c} **b**0057908 and 1)105-76-0-8 THUI Gonge 6/11/07 Robert J. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patterson, M.D. 800 5 TALBOI STMK HABL'S 32. Pastrar's Signature JUN 1 3 2007 31. Date filed (Month, State Registrar

DHMH 17 Rev 1/2001

Physician
/Medical
Examiner

Funeral
Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Saltimore, Maryland 21215-0036

Physician /Medical Examiner

death certificate be executed

Box 68760.

P.O.

or Vital Records,

Division

To the Hospital or Attending

within 24 hours after To the Funeral Dire

ours after death.

Peral Director: After this certificate has been signed by the attending physician and

Filled in by the funeral director, page 2 should be detached for use as the burial-transit

2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Day DANNY WAYNE BTSH 0.5 2007 0435 06 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death ALLEGANY WMHS - MEMORIAL CAMPUS CUMBERLAND If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex Days Hours 1**X** M 2□ F Months Min. 61 215-46-0066 05/25/1946 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🔯 No Director Cumberland MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 10301 Christie Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify <u>≽</u> 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Courier Courier Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tyler Bish Hoge Josephine Agnes Burton ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeffrey T. Bish / Brother HC 86, Box 1A, Green Spring, WV 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1 □ Durna. 4 □ Donation 5 ☐ Other (Specify) Cumberland Crematory 06/08/2007 Cumberland, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Restiratory Failure 3 days disease or condition resulting in death) Due to (or as a consequence of): Aspiration Pneumonia Sequentially list conditions Due to for as a consequence of: Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Chronic Obstructive Pulmonary Disease Years Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Renal Failure, Diabetic Nephropathy, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Diabetes Mellitus, Dialysis Discontinuation, 24a. Was an autopsy 1□ Yes 2 XI No Coronary Artery Disease 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of conficer 29d. Date signed (Month, Day, Year)

M&X State

31. Date filed (Month, Day, Year)

JUN 0 8 2007

Registrar

517 Oldtown Road, Cumberland, MD

Name and address of person who completed cause of death (Item 23a) (Type, Print)
 Nagaratnam A. Ranjithan, M.D., 51

egistrar's Signature

		1	For State of Maryland / Departm State Certific	cate of Death		a. No. O O B T	in any post of the
			RegIstrar 1. Decedent's Name (First, Middle, Last)	alo or boatt	2. Date of Death	6.001	3. Time of Death
1	Physicia /Medic		Orville Bridges		Month 06	06 Year 07	2045 [™]
,	Examin		, and a second for the second for th	City, Town, or Location of Death		4c. County of Death	
			WMHS Braddock Campus 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Cumberland nder 1 Year If Under 24 Hrs.	8. Date of Birth	Allegany	Place (State or Foreign
ľ	Funeral Director		217-14-4778 19 Mor		(Month, Day, 1) December 04	rear) Cou	yland
	aryland show dat		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	he Ma 28a-f	Director	Maryland Allegany Frostburg 10e. Street and Number 10	f. Zip Code	10	g. Citizen of What Cou	/
	with a or the r		329 Barnard Street			J.S.A.	,
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	1 □ Never Married 2 Married 1 M Yes 2 □ No W W H	21532- Decedent of Hispanic Origin? (Sp. specify Cuban, Mexican, Puerto		14. Race - Ameri Black, White	
21215-0036	ours af	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: Korea	es 2 No Specify:		Specify: Whi	ite
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Maryland		To B	Daniel O'Connel Bridges	Anna Frar	ices Bennett		
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Baltimore,	of of		20a. Method of Disposition 1 □ Burial 2 【Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition cemetery, crematory Cumberland Cre	1		Cumberland M	
Ħ				ne and Address of Facility	ne 07, 2007 (Juniochand M	ar yılarıcı
B	permit. Departr Importa any Inji		John R. Weret Du	rst Funeral Home, 57	Frost Ave., F	rostburg, MD	21532
			23a. Part. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	e mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition resulting in death)				
	/Medical Examiner		Due to (or as a consequence of):				
		-	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	e/			
	cuted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter the certific to Cause (Disease or injury that initiated events c.				
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		/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of deli	very
). Box	The law requires that the death cert ate has been signed by the attending bage 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	pric pregnancy er (specify)		Month	Day Year
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or Vital Records,	The lav	Completed	The state of the s		autops perform	ned? death?	completion of cause of
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۲ ک	hysic this ce	ဥ	1 Yes 3 No Hospital: Timpatient 2 ER/Outpatient 3			nce 6 Other (Spec	cify)
on C	ding P	ion:	27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month, Day Year) 2 Accident investigation	28c. Injury at Work? /I 1 ☐ Yes 2 ☐ No	28d. Describe ho	w injury occurred	
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ă	s after al Dire	Serti	4 ☐ Homicide determined building, etc. (Specify)		City or Town	, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	edical Certification:	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occ provided in the death occurrence of the death occurrence occurrence of the death occurrence occurrence occurrence of the death occurrence occur				
	To the vithin To the complete	Me	29b. Signature and title of certifier Stanley J. Matyar. K. D.O.	29c. License number	29	9d. Date signed (Monta	h, Day, Year)
	31.00		stanley J. Maryark, D.S.	H0053856	5	JUNE 7,	2007
	ZIVA		30. Name and address of person who completed cause of death (Item 23a) (Type, Print	HOOS3859 Seten Orine, B	Cumber	land, Mt	RYLAND
	71 5-3		Stanley J. Matyarik, p.o. 400 31. Date filed (Month Day, Year) 32 Pegistrar's Signature	reion urine, B	raddock	(Campus	WMITS
	Sta	ate	31. Date filed (Month, Day, Year) 32 flegistrar's Signature	1. 2			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 7 1 - Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12:10 PM Belav kwedage June 2007 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (not institution, give street and number) 4c. County of Death Examiner The Johns Hopkins Hospita Baltimore City 8. Date of Birth (Month, Day 1 Year) 1956 Il Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2X□ F 50 Yrs. 557-91-6105 Director ETHIOPIA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show S 1 and a succession of the succession of the subsection of the su 1 No Yes 2 No **Funeral Director** LOS ANGELES VALLEY VILLAGE CA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 91607 UNITED STATES 11958 KING ST., 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No
If Yes, Give X
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify à Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4Yrs Elementary/Secondary (0-12) SECRETARY **GOVERMENT** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MENBER TUMELISAN BELAY SAHLU ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28170 ROYAL RD CASTAIC CA., 91384 <u>YOHANNES BELAY / BROTHER</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if its any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State FT. LINCOLN CEMETERY 6/11/07 BRENTWOOD, MD 4 □Donation 5 □ Other (Specify) of Funeral Service Licenses CAPITOL MORTUARY 22. Name and Address of Facility 41425 MARYALAND AVE., N.E. WASHINGTON, MD. 20002 23a. Parf1. Enter the disease shock, or heart lailure. omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Encepholopet **Physician** Hepetic /Medical Due to (or as a consequence of): Examiner Failure 5 quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed iver We Due to (or as a consequence of): ettending physicien a for use as the burial-Division of Vital Records, P.O. Box 68760, mears Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performe certificete 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation Diractor: 3 ☐ Suicide 6 Could not be 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🔲 Homicide within 24 hours a Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) > Medical Doctor Res - 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hopkins Hospital, 600 North Wolfe Street El. Boritz, The Johns 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Month Day Year **Physician** CHRISTOPHER VIRGINIA 06 20 2007 1034 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day,) May 25, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days MD 214-05-8338 91 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. Count 28a-f show an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at MD Allegany Cumberland Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 13808 Cardinal Drive death v Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: white 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) owner and co-founder Christopher Photo Lab 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grover Cleveland Shillingburg Edith Taylor Shillingburg P 19a. Informant's Name/Relationship (Type. Print)
Anne Gregg Mazzone daughter 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State, Zip Code) 16410 Lakewood Dr. Rawlings MD 21557 20b. Place of Disposition (Name of 20a. Method of Disposition
1 ☐Burial 2 ☐Cremation 3 ☐Removal from State Date 20c. Location - City or Town, State Hillcrest Memorial Park 6/23/2007 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name Scarbetti Functial Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme te Cause (Final disease or condition resulting in death) **Physician** KESPIRATURY 4 DAY /Medical Due to (or as a consequence of) Examiner DAYS LATERAL TWEDMONIE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) inecords, P.O. Box 68760, $\mathcal{E}_{\mathcal{S}}$ The law requires that the death certificate be executed bunial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 : autopsy perform 2 2 No the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **№** No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D14865 UNE 2007 bushaws MP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 ROBUSTIANO BARRERA, 500 MEMORIAL AVE. CUMBERLAND MD 21502 31. Date filed (Month, Day, Year) 32. gistrar's Signature State JUN 2 6 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death **Physician** 10:42 AM JUNE 12 2007 GERALD WAYNE CONLEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner QUEEN ANNE'S 604 VICTORIA DRIVE STEVENSVILLE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) 1**X**M 2□ F Months Days Hours Yrs. SEPTEMBER 8, 1955 WEST VIRGINIA 214-66-1739 51 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MARYLAND QUEEN ANNE'S STEVENSVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's ō 604 VICTORIA DRIVE 21666 UNITED STATES Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 5 1 ☐ Yes 2 No Specify Specify: WHITE ð 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 WAREHOUSE MANAGER MANAGEMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental I s marked CLAIRE L. NICEWARNER THOMAS F. CONLEY ဥ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2.
Department of Health at importent: If Item 27 is eny injury or other trau ROBIN CONLEY/WIFE 604 VICTORIA DRIVE, STEVENSVILLE, MARYLAND 21666 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition JUNE 15 1 XBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 2007 WOODLAWN MEMORIAL PARK EASTON, MARYLAND 21. Signal 19 Myneral Service Licensee HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Cell Carcinoma 4 years Renal Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine attending physicien and for use as the burial-transit certificate be execut Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) P.O. I cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate After this certification, I 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No after death Director: A investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital c within 24 hours af To the Funeral D completely filled in 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Maryland D31586 June 13, 2007 Tw 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Reservoir Rd NW Washington DC 20007 MO Nancy A Dawson 3800 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 14 2007 Registrar

DHMH 17 Rev 1/2001

Amended #25, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06/11/07, Allegany County State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June 07, 2007 **Physician** 07:00 P M Floyd W. Catherman, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 168 Mount Pleasant Street Allegany Frostburg If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1⊠M 2□F 220-10-1484 85 Pennsylvania June 27, 1921 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 28a-f shov 1 Yes 2 No Allegany Frostburg Directo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 168 Mount Pleasant Street 21532-U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW.II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Completed by 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) salesman hardware store al Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be of Health and Menta item 27 is marked Paul M. Catherman Frances D. Shope ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21157-23 Shamrock Circle Westminster daughter Diane Smith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park June 11, 2007 Frostburg Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Pay. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ck, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of) Vital Records, P.O. Box 68760, Physician/Medical the as attending IF FEMALE asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Day in the past 12 months 1 ☐ Yes 2 ☐ N 4☐Pregnant at time of death 5 Other (specify) the detached 9☐Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> Sease 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performe Prost HO 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ₹Ves 2[**X** No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 0 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 Natural 2 Accident 2 □ No death. 1 Tyes nours after death. 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P 5/10A T, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) San nas Larn 32. Registrar's Signature State Registrar

		For State Registrar	State o	f Maryland	-	artment of H		Mental Hygi	ene () g. No.	07	20576
		Decedent's Name (First, Middle	, Last)			•		2. Date of Death Month	Day	Year	3. Time of Death
Physi		Naomi L. Colosimo						June 12			01:30 A
/Med Exam		4a. Facility Name (If not institution	give street and nu	mber)		4b. City, Town, o	Location of Death	1	4c. Coun	ity of Death	1
		Beverly Living Center					Cumberland		Allega		
Funera	ai	5. Social Security Number	6. Sex 1 ☐ M 2 🕱 F	7. Age (In yrs. I		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			place (State or Foreign untry)
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pug *		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
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the N	Directo	Maryland Alleg		Lav	alc	10f. Zip Code		10	Og. Citizen o	of What Co	untry?
with Sa or			anor St.			21502-		1	I.S.A.		
Jeath Ins 23	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No-	14. R	ace - Ame	ncan Indian,
r Iter			ied 1 ☐ Yes	2 🔀 No		If Yes, specify Cuba 1 ☐ Yes 2 🕱 No	Specify:	o rican, etc.)	Spec		3, 610.
ours a	þ		If Yes, G Year or I	Dates:		10185 200110	эрөспу.			Whit	
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and 2 should be filed within 72 hours after death with the Marylan F Health and Mental Hygiene. The Health and Mental Hygiene and the Hygiene	2	George Davis 19a. Informant's Name/Relations	hin (Type Print)		19b. Maili	na Address (Street		ural Route Number.	City or Tov	vn, State, Z	Zip Code)
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1 and 1 Health tem 27		Betty Twigg 20a. Method of Disposition	uau	20b. P		osition (Name of matory or other pla					Town, State
It Pages 1 and 2 should be filed within 72 hours at trainent of Health and Mental Hygiens, arrients of Health and Mental Hygiens, arrient: If item 27 is marked other than "naturel", or nighty or other traumstic event, the Medical Exampliary or other traumstic event, the Medical Example.		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		i State	-	emorial Park		ne 15, 2007 F	rostbur	a Ma	ryland
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permil Depar Impor	ä	John 1	Ru	ret		Durst Funera	l Home, 57	Frost Ave., F	rostburg	g, MD	21532
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The lay	į							perform	med? 20 No	death?	
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DIVISION I or Attending after death. I Director: Afte		27. Manner of Death Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homicide detern	mined 200. Fla	ce of Injury - At h Iding, etc. <i>(Speci</i>	iome, farm, s fy)	treet, factory, office		City or Tow		umber or H	ural Route Number,
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na	W	625 Vent	AUR. ()	umbe	iden	nd, MIS	. 21500	} .	,,		1 ' '
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		1	For State Registrar	State of Ma	•	Certificat				leg. No.	007	205//
r	45		Decedent's Name (First, Middle, Las	t)					Date of Dea Month	Day	Year	3. Time of Death
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20	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. Ind Mental Hygiene. Inakted other than "natural" or items 23a or 28a-f show marked other than "natural" or items 23a or 28a-f show marked other than "dedical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ∑ Yes 2 □ N If Yes, Give Year or Dates:	40-6	If Yes, spe		n, Mexican, Puerto Specify:	Rican, etc.)	1 -	Black, White, Specify:	Black
	72 hour natural	sted b	15. Decedent's Education (Specify only highest gra	ducation		Decedent's Usu (Give kind of wo	rk done o	luring most of work	ing	16b. Kind	d of Business/Ir	
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a	2 sho and 1 Is ma		19a. Informant's Name/Relationship (_		and Number or Rui			Town, State, Zi 21502	p Code)
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Division	l or Attend after death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	A 200. 1 lace of its	jury - At home, tc. (Specify)	farm, street, facto	ory, office		28f. Location City or To	(Street an own, State	d Number or Ru	ural Route Number,
_	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical Co	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis and manner s	of examination a	ge, death occurre and/or investigation	ed at the t	me, date and place opinion, death occ	e, and due to the urred at the time	e, date and	place, and due	e to the cause(s)
	To the within To the complex	Me	29b. Signature and title of certifier	-1 M	/	2		se number			te signed (Mont	
	HIIVA		Jan	Kla	me		DO	054004		Ju	ne 11,	2007
•	ned		30. Name and address of person who Shiv C. Kh.	completed cause of anna, M.D.	death (Item 23a , 1221) (Type, Print) Nationa	al Hi	ghway, La	aVale, 1	Maryl	and 21	502
	Si Regis	ate trar	31. Date filed (Month, Day, Year)		trar's Signature	bout ?						
			ADIL T A COL	34	J. A.	MARY E. GING						

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar		State o	f Maryla		oartmer e <i>rtifica</i> :			and Mo	ental Hy	giene (107	2057)
	Physici /Medic		Decedent's Name (First, Michael James M. Cross	dle, Last)								2. Date of De Month June	nath Day 13, 2007	Year	3. Time of Dea 05:15 AM	ith M
	Examir		4a. Facility Name (If not institut Frostburg Village Nu	irsing	Care Cen	ter	· · · ·		F	rostbur	g		Alle	ounty of Dea		
8.	Funeral Director		5. Social Security Number 212-12-8738	6. Sex	M 2□F	7. Age (In yr 89	s. last birthda Yrs.	Months	Days	If Under	Min.	8. Date of Bi (Month, D. ecember 2	ay, Year)	3 . C	thplace (State or Fo puntry) Aland	reign
	and w		Usual Residence of Decedent 10a. State 10b. Coun	tv		10c. (City, Town or	Location							10d. Inside City Li	mits
	Aaryli sho	ō		gany			stburg			*					1 V 2 Yes 2]No
	28a-	Director	10e. Street and Number29 Bo		ane			10f, Zi	p Code			-	10g. Citize	on of What C	ountry?	-
	3a or	O	29 15	om s D	aic			2153	32-				U.S.A.			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-1 show any injury or other traumatic event, the Medical Exercitar must be notified at 200s.	by Funeral	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Divorce	arried	12. Was Dece Armed Fo 1 X Yes It Yes, Gin Year or D	edent Ever in rces? 2 No re ates: WW	U.S. 1	3. Was Dece If Yes, spe		ispanic Origin, Mexican	gin? (Spec n, Puerto F	city Yes or N Rican, etc.)		Race - Am Black, Whi Specify: Whit	te, etc.	
ŏ	2 hou	ted	15. Deced		cation		16a. De	cedent's Usu	al Occup	ation	t of working			of Business		
215	thin 7.	Completed by	(Specify only high Elementary/Secondary (0-12		College (1	-4or 5+)	life	ve kind of w	ise retired	during mosi 1)	t of workin	ig				
21	ygien ygien yerth t. Ibe	Con		ــــــــــــــــــــــــــــــــــــــ			teache	1					1	of Educa	ion	
Baltimore, Maryland 21215-0036	Mental H Mental H arked oth	To Be	17. Father's Name (First, Middle Alexander Cross							Eva Lo	ongridg					
Nar	12 sh h and 7 ia m traum		19a. Informant's Name/Relation Ann Applegate	nship (Ty	рө, Print) daugl	nter		iiling Addres Summei				i Route Numb I gfield	oer, City or i		Zip Code) 22153-	
e,	1 and Health em 27 ther tr		20a. Method of Disposition		daugi	-	. Place of Dis					ate		ation - City or		
5	Pages nent of int: If it		1 🗆 Burial 2 Crematio		emoval from	C1-1-	cemetery, comberlance	rematory or	other plac	(9)				land Ma		
Baltin	permit. P Departme importan any injuri		4 Donation 5 Other 21. Signature of Funeral Service		19) err	1		22. Name a	nd Addre		ty	st Ave., l	-			
8760,	The law requires that the death certificate be executed as being read by the attending physicien and page 2 should be detached for use as the burial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, the cause interior Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to	(or as a cons	equence of):	RTE	Zy_	0183					Onset and Deal	Yes
P.O. Box 6	the death certifica by the attending phace of the control of the c	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	2		ointh 2 ∏ Fe nantattime o	etal death	3 □Ectopic p 5 □ Other (s		,			23	8d. Date of de Month	livery Day Year	,
ds, P	 requires that the death been signed by the atte should be detached for 	þ	Part II. Other significant cond	ST/	ntributing to d	eath but not r	esulting in the	underlying	cause giv 1 Lea	en in Part I			tobacco use		o the cause of death	
Division of Vital Records,	: The law rec cate has bee page 2 shot	Completed	CARAGE	В	145 V	yry T	AM1	4					s an opsy ormed2 2 No	24b. Were a prior to death?	utopsy findings avai completion of causi s 2 No	ilable e of
<u>≅</u>	tician: Th certificate rector, pag	Be	25. Was case referred to medi examiner?	-	lospital:				Oth			(Check only				
of	Phys this ral du	. To	1 Yes 2 No		28a. Date	of Injury	ER/Outpa 28b, Time		28c. Injur	4 (41)		ne 5 Res			ecify)	
on	ding F h. After funera	ton	1 Natural 5 ☐ Pen	ding stigation	(Mon	th, Day Year)	Inju		Wor	k? Yes 2□		.00. 00001100	non injury	00001100		
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	To the Hoepitei within 24 hours of To the Funerei completely filled	edicai	29a. Criffier Certif	ying Phys al Exemi	sician: To the ner: On the b and man	best of my k asis of exami ner stated.	nowledge, di nation and/o	ath occurred investigation	d at the tin	ne, date an pinion, dea	nd place, a ith occurre	and due to the ed at the time	cause(s) a date and p	and manner a place, and du	s stated. e to the cause(s)	
	To t To tl	Σ	29b. Signature and title of cert	fier	01			29	c. Licens	e number			29d. Date	signed (Mon	th, Day, Year)	
	3/101	4			Hh	elle		1	126	90	7		JUNE	213	2007	
	nes		30. Name and address of pers Harjt 5	dho	mpleted caus	se of death (II	23a) (Ty	oe, Print)	Wa/	sh Ro	l, C	umb	erlan	d, Mo	in, Day, Year) 2007 aryland 2	150:
	Sta Regist		31. Date filed (Month, Day, Ye	4 2	32. F	sistrar's Sig	nature	Goard			/			,	•	

			Flea	State of N				lealth and N		•	
		,	1 - For State Registrar	Oldic of I	viai yiai		rtificate of		, ,	g. No. ? A A 7	0027)
T.	C. 11		Decedent's Name (First, Middle)	e, Last)					2. Date of Death	1 2 5 1	3. Time of Death
	Physici /Medic		Mildred			Cı	JOZZO		June 3	Day 2007	4:50 A M
	Examin		4a. Facility Name (If not institution	, give street and number	er)		4b. City, Town, o	or Location of Death		4c. County of Deat	
	The second secon		Lorien Mount					Airy		Carrol1	
Ы	Funeral		5. Social Security Number	6. Sex 7. 1 ☐ M 2 🕱 F		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birti	hplace (State or Foreign untry)
1	Director		578-09-9241 Usual Residence of Decedent		89)			6/26/1	917 wasn	ington DC
	ylanc how		10a. State 10b. County	o !	10c. Cit	y, Town or Lo	cation collton				10d. Inside City Limits
	e Mal la-f sl	ctor	Prince	e George's			.0110011				1 XYes 2 No
	or 28	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	untry?
	s 23a	ral	7417 Leahy Rd	Trans.		a 1.		784		USA	
	item item	Funeral [11. Marital Status1 ☐ Never Married 2 ☐ Marrie	12. Was Decede Armed Force ied 1 ☐ Yes 2.	s?	.5.	If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
39	al", or	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Date			1 ☐ Yes 2 🖾 No	Specify:		Specify: Whi	te
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed	15. Decedent (Specify only highes	t's Education		16a. Dece	dent's Usual Occup	pation	king 1	16b. Kind of Business/	
2	ithin and "I	nple	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	DO NOT use retire	during most of wor d)	Kiiig		
12	led w lygier her th		12	[Hor	nemaker	10 Markada Nas	an (Final Adiabata &	Own Home	
anc	d be find he find he ed of	Be	17. Father's Name (First, Middle,	Last)				Mildred	ne <i>(First, Middle, N</i>	raiden Surname)	
Ë	should nd Me mark matic	ဥ	William Spahr 19a. Informant's Name/Relationsl	hin (Type, Print)		19h Maili	nn Address (Street			City or Town, State, 2	7in Code)
Ma	nd 2 salth ar 27 is 27 is r trau		Barry Cuozzo /					Monrovia			p code)
Je,	ss 1 a of Hee item		20a. Method of Disposition		20b. F	Place of Disponent	osition (Name of	(ce)	Date 2	20c. Location - City or	
Ē	Page nent c		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		te For	ct Line	coln Ceme	tery 6/8/	/07	Brentwood,	MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licensee	1					3401 Blade	nsburg Rd
9.			23a Part I Enter the disease or	complications that cause	sed the deat			MD 20772		eet	Approximate
	Dhysisian		23a Part 1. Enter the disease, or shock, or heart failure. List mediate Cause (Final	only one cause on each	n line.	(2.)	TAITOIA	conni	21 House	orthage	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		as a consec		LICITORI	SCHTOTT	" "(CIPIC	or pinge	1010
	Examiner		Proceedings that a second		mic						WIC
Į ė	P .≒	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consec	juence of):	211.1	(
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Ativ	as a consec	tibi	illati	ON C			MOS
760,	te be executed ysician and ie burial-transit	calE	,			ews,	121)				Mac
687	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit			d. 7790	34	0103	1010				mos
Вох	n certi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			7			23d. Date of del	ivery
œ.	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ♣ No	1 □Live birth 4 □ Pregnan 9 □ Unknow	t at time of o		⊒Ectopic pregnand ⊒ Other <i>(specify)</i> _	;y 		Month	Day Year
P. O.	that the dened by the stacked to	hys	9 Unknown								
	w requires that been signed I should be det	ρ	Part II. Other significant condition	ons contributing to deat	n but not res	sulting in the t	ınderlying cause gi	ven in Part I.	23e. Did tob	acco use contribute to	
Ö	w requir been si should	Completed									obably 4 Unknown
Rec	has t	шb							24a. Was ar autops perforn	y prior to	itopsy findings available completion of cause of
ā	iclan: Th certificate ector, pag		25. Was case referred to medical	-				00 81(8	1□ Yes 2	No 1 ☐ Yes	2 No
or Vital Records,	ysicia is cert directa	To Be	examiner? 1 Tes 2 No	Hospital:	atient 2]ER/Outpatie	nt 3 DOA Oti	hor:	ith <i>(Check only one</i> lome 5 ☐ Beside	nce 6 ☐Other (Spe	cify)
0	Attending Physician: r death. ector; After this certific. by the funeral director, I		27. Manner of Death	28a. Date of I	njury Day Year)	28b. Time of Injury				w injury occurred	y/
<u>S</u>	tendir eath. or; A	atic	1 Natural 5 Pendin 2 Accident investig	gation	,,	,.,		Yes 2□No			
Division	i or Attending I after death. Director; After I in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 286. Place of	injury - At h etc. (Speci		reet, factory, office		28f. Location (Sti City or Town	reet and Number or Ru , State)	ıral Route Number,
	Hospital 24 hours a Funeral I stely filled	Ce	29a. Certifier 1 Certifyin	ng Physician: To the be	est of my kno	owledge dea	th occurred at the t	ime date and place	and due to the ca	ause(s) and manner as	stated
		Medical		Examiner: On the basi and manner	s of examina						
	To the within To the Comple	Me	29b. Signature and title of certific		111	10.	29c. Licen	se number	G 25	9d. Date signed (Mont	h, Day, Year)
			· all	n Kei	lle	100	UD5	414	7 3	Tune 4	2007
0	(3)		30. Name and address of person	who completed cause of	of death (be	23a) (Type	, Print)	1 1	Ten	eick, Md	10172:
	-01	to	31. Date filed (Month, Day, Year)	4 MI S	istrar's Sign	V/ /7	ouse A	vc, 0-1,	, rebes	eicic, mg	01101
	Sta Registr		JUN 1 2 2007	Berein)	D. A	all					

							delible Ink.		-		_		
	-	For State Registrar				-	tificate of			Reg. No	1011 15 17)	158
Physicia		1. Decedent's Name (First, M	fiddle, Last)						2. Date of I	Death Day	y Year	_	e of Death
/Medic		Richard		nypack		avis	4. 67. 7	1 5 10	June	21	,2007		30 AM
Examin	er	4a. Facility Name (If not instit					4b. City, Town, o		eatn		. County of Deat Allegany	1	
Funeral	8	Lions Nursin 5. Social Security Number	6. Sex	7. Ag		ast birthday)	If Under 1 Year	If Under 24 H	lrs. 8. Date of I	Rinth	n Birtl	nplace (Sta	ite or Foreign
Director		041-22-7897	1 □ M	2 F	79	Yrs.	Months Days	Hours Mi	in. Nov 2	3, 19	27	NJ	
and t		Usual Residence of Decedent 10a. State 10b. Co			10c. City	, Town or Lo	cation					10d. Insid	e City Limits
Maryl -f sho	to	MD A	llegany			LaVa	ale					X □	res 2 □ No
or 28a	Funeral Director	10e. Street and Number		_			10f. Zip Code			10g. Cit	tizen of What Co	untry?	
23a cust be	ral	1110 Braddo						21502			USA		
er dez	nue	11. Marital Status 1 □ Never Married 👢□	_ A	/as Decedent .rmed Forces? ¶∏Yes 2∏	?	S. 13. \	Was Decedent of H f Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or uerto Rican, etc.)	No-	14. Race - Ame Black, White		١,
irs aft	by F	3 Widowed 4 Divo		Yes, Give ear or Dates:			1 □ Yes 2 No	Specify:			Specify: wh	nite	
72 hou natura lio i E		15. Dec	edent's Educatio lighest grade con	n nnleted)		16a. Deced	dent's Usual Occup	ation	workina	16b. K	(ind of Business/	Industry	
ithin ne.	Completed	Elementary/Secondary (0-		College (1-4or	5+)		kind of work done		g	Cit	v of Bolti	moro	
iled w Hygiel ther tl nt, th		17. Father's Name (First, Mid	ddle. Last)			Direct	or of Marl		Name (First, Midd		y of Balti o Surname)	more	
ld be ental ked o	To Be	William Fa		is				Mary	Penny	packe	er Davis		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Rela Margie Davis		Print) wife	;		ng Address (Street O Braddo			nber, City /ale	or Town, State, 2	Zip Code) MD 21	502
of Heal		20a. Method of Disposition		14 000	20b. P	Place of Dispo emetery, crei	sition (Name of matory or other pla	ce)	Date	20c. L	ocation - City or	Town, Stat	
Page nent c ant: If ury or		1 ☐ Burial 2 🛣 Crema: 4 ☐ Donation 5 ☐ Oth		val from State			neral Home		6/21/2007	' C	resaptov	/n	MD
permit. Departi Importi any inj once.		21. Signatuly of Juneral Ser	rvice Licensee	011	111	22	2. Name and Addre Scarpel						
007.60		236 Part1 Finter the disease	or complication	O that cause	od the deat	h. Do not ent			ue: Cumber		D 21502	Approx	imate
Physician /Medical Examiner		234. Part1. Enter the disease shock or heart failure. Immedi in Cause (Final disease or condition resulting in death)	List only one ca	1)	leins	on V	15 can			, uoo,		Interva Onset	Between and Death
executed in and ial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Exit of Jaying Cause (Disease or injury that initiated events resulting in death) Last	b	Due to (or as							3		
eath certi aftending for use a	Physician/Medica	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		f yes, outcom 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	Ideath 3	□Ectopic pregnanc	y		_	23d. Date of de Month	livery Day	Year
w requires that the deben signed by the should be detached	by	Part II. Other significant co	nditions contrib	uting to death	but not res	ulting in the u	nderlying cause gi	ven in Part I.			use contribute to		e of death?
	Completed			···						utopsy erformed?	prior to death?	completion	ings available of cause of
sician: Th certificate rector, pag	Be	25. Was case referred to me examiner?	edical Hosp	ital:		I E D / O . A N -	or post Ot	her: V	Death (Check on		- Co		
ding Phys h. After this tuneral dir	5	1 ☐ Yes 2 No 27. Manner of Death	2	8a. Date of In	jury	ER/Outpatie 28b. Time of		$\longrightarrow \longleftarrow$	ng Home 5 R		ury occurred	ecity)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident in 3 Suicide 6 □ C	ending evestigation could not be etermined]Yes 2 □No		on (Street a Town, Sta	and Number or R te)	ural Route	Number,
e Hospitai 124 hours a e Funerai iletely filled	edical Ce				of examina		th occurred at the to						use(s)
To the To the Compl	Me	29b. Signature and title of c	ertifier	0			29c. Licen	se number		29d. D	ate signed (Mon	th, Day, Ye	ear)
		•	V	Tho			井	330	180	Ju	ine al	,20	07
6		30. Name and address of po	erson who compl	eted cause of	death (Iter	n 23a) (Type Ken +	Ave. C	umbe	rland.	MD	2150	2	
St	ate	31. Date filed (Month, Day,	6 2007	2. Regis	trar's Sign	ature	ale)		,				

			1 - For State Registrar	State of M		d / Depa	artmen		and N	lental Hyg		20581
			1. Decedent's Name (First, Middle, La	est)						2. Date of Deat Month	h Day Year	3. Time of Death
	hysici: /Medic		Vera Ida D	ole						June 9	2007	9:43A M
	xamin		4a. Facility Name (If not institution, gir	ve street and number)			4b. City,	Town, or Location	n of Death		4c. County of Death	1
			Mallard Bay C	are Cente	er			ambrid			Dorches	ter
	neral ector		008-16-0810	Sex 7. Ag 1 □ M 2 💢 F	90 (In yrs. 1 85	ast birthday) Yrs.	Months	1 Year If Und Days Hours		8. Date of Birth (Month, Day, NOV • 14	Year) 9. Birth Con Ver	pplace (State or Foreign intry) mont
and			Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	ocation					10d. Inside City Limits
death with the Maryland	offilled	ector	MD Dorche	ester				ridge				1 □Yes 2X No
it with	unit Den	Funeral Director	10e. Street and Number 1010 Hudson Roa	ad			10f. Zip	2161	3	1	0g. Citizen of What Cor USA	untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merel Hygiene.	Examiner m	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	,			dent of Hispanic only Cuban, Mexic 2X No Speci		ecify Yes or No- Rican, etc.)	14. Race · Amer Black, White Specify Whi	, etc.
13-C	fedical	Completed	15. Decedent's E (Specify only highest gr	ade completed)		16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	al Occupation rk done during m se retired)	nost of work	ang	16b. Kind of Business/I	ndustry
with iene.	2	E	Elementary/Secondary (0-12)	College (1-4or	5+)			vorker			electronic	CS
2 should be filed within 72 hours after and Mental Hygiene.	tic event,	To Be C	17. Father's Name (First, Middle, Las Elmer Raymond	1)						e (First, Middle, M ce Burdi	·	
MICH Y	r treumal		19a. Informant's Name/Relationship Eddie Wheatley	(Type, Print)			_			al Route Number, mbridge,	City or Town, State, Z	ip Code)
S a S	othe		20a. Method of Disposition		20b. P	lace of Dispo emetery, crei			the state of the s	_	20c. Location - City or	Town, State
Page G	7 0		1 ☐ Burial 2 🖾 Cremation 3 { 4 ☐ Donation 5 ☐ Other (Speci			isbury			6/18	/07	Salisbury	, MD
Dallingo Dermit. Pages Department of	in in		21. Signature of Funeral Service Lice								eral Home	
28.	eny ir		> Bikik	>						ambridge		
Phys			23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	nplications that caused one cause on each li a	d the death ine.	n. Do not ent	ter the mod	le of dying, such	as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
Exan	dical niner			Due to (or as	a consequ	ience of):	in in	bach	j			
D	Ħ.	iner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	а оспанці	uanea of):		0				
ecute	trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as	rev							
ate be executed	nysicien he buria	cal		_ d	a consequ	anice oi).						
The law requires that the death certification has been signed by the attending of	been signed by the attending physicien and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	∃Ectopic pi ∃Other (sp				23d. Date of deli Month	very Day Year
Fes that if	be detac	þ	Part II. Other significant conditions	contributing to death b	out not resu	ulting in the u	nderlying o	ause given in Pa	ırt I.		pacco use contribute to	
w requires t	should	Completed								1 □ Ye		obably 4 DUnknown
	ins certificate nes al director, page 2 :									autops perform 1 Yes 2	ned? death?	topsy findings available completion of cause of
VIC	recto	Be	25. Was case referred to medical examiner?	Hospital:						h Check only on		
5 £ 5	in diameter	5	1 Yes 2 No 27. Manner of Leath	1 L Inpatie		ER/Outpatier 28b. Time o		A Durov at	Nursing Ho		ence 6 Other (Spec	ufy)
	fune	tion	Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	Injury	м .	8c. Injury at Work? 1 ☐ Yes 2	□No	200. 20001120110	W Injury Coodings	
LIVISION OF VICE al or Attending Physicien: after death.	d in by the	Certification	2 Accident Investigation 3 Suicide 6 Could not lidermined	De Blace of In	jury - At ho tc. (Specify	me, farm, str				28f. Location (St. City or Town	reet and Number or Ru n, State)	ral Route Number,
To the Hospital or Attending Physikin 24 hours after death.	letely fille	Medicai C	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	of examina	wiedge, deat tion and/or in	h occurred vestigation	at the time, date , in my opinion, c	and place, death occur	and due to the ca red at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To the within	E O	ž	29b. Signature and title of certified	1			290	. License numbe	er	2	9d. Date signed (Month	•
) are	y MI)				1) 479	924		6.11-07	
			30. Name and address of person who HOMM THAN	Jy 502	RY	RN	Print)	CAMER	1000	MO	2/6/3	
R	Sta legistr		31. Date filed (Month, Day, Year) JUN 1 2	2007 32. R. Astr	rar's Signa	ture	had	ار)				

DHMH 17 Rev 1/2001

		1	For State Registrar	State of Mary	/land /		rtment of				giene Reg. No.	2007	205	02
			Decedent's Name (First, Middle, in the control of the control	Last)						2. Date of De Month	ath Day	Year	3. Time of E	eath
	Physicia	_	MICHAEL JAMES	DOMBR	OSKY					06	07	2007	1141	М
	/Medic Examin		4a. Facility Name (If not institution, g	give street and number)			4b. City, Town,				4c. C	County of Death		
		Δ.	MEMORIAL HOSPIT				CUMB1	ERLAND		0 D () -(D)		ALLEGAN		F
	Funeral		o. o.o.	. Sex 7. Age (li 1 1 1	in yrs. last	' birthday) Yrs.	Months Days		Min.	8. Date of Bir (Month, Da	y, Year)	Cot	place (State or intry)	roreign
- K	Director	-	217-54-1073 Usual Residence of Decedent	30					10	07/20/	1950	l_Mar	yland	
	and tw	-	10a. State 10b. County	10	0c. City, T	own or Lo	cation						10d. Inside City	Limits
	Maryl f sho led a	ğ	MD Alle	egany		Cun	nberland						1 X Yes	2∏No
	28a	ec	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Cor	intry?	
	3ao	a D	221 Pear St	treet			2	1502				USA		
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If the m 27 is marked other than "natural", or items 23a or 28a-f show it items 27 is marked other than "natural", or items 2 to notified at or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S.		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2🎇 No			cify Yes or No Rican, etc.)		4. Race - Amer Black, White Specify:		
21215-0036	hours tural	q pe	15. Decedent's			 16a. Dece	dent's Usual Occ	upation			16b. Kin	d of Business/l		
7	n 72 "na" ledici	Completed	(Specify only highest	grade completed) College (1-4or 5+)		(Give life.	kind of work don DO NOT use retii	e during mo red)	st of workii	ng				
12	withi iene. thar	E O	Elementary/Secondary (0-12)	2		Recr	eation (Counse	lor		Parl	ks & Re	<u>creatio</u>	n
	rould be filed within a Mental Hygiene. narked other than natic event, the Me	BeC	17. Father's Name (First, Middle, L.	ast)				1		(First, Middle			••	
lan	uld be denta rked ric ev	일	Eugene	Francis		brosk	-		garet		Ursla		Hannon	
<u>~</u>	2 should and Men is marke raumatic		19a. Informant's Name/Relationshi	p (Type. Print)			ng Address (Stre							
Σ	and 2 salth n 27 i		Richard Dombros				Pear St						21502	
ore	of He of He fiten		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation	Bemoval from State			osition (Name of matory or other p			Date		cation - City or		
Ĕ	Pag ment ant: I ury o	ĺ	4 □ Donation 5 □ Other (Sp	ecify)	Cumb		nd Crema					berland		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		21. Signature of Funeral Service L	C. aden	u/	/ 1	2. Name and Add 104 Deca	tur St	treet	, Cumbe	erlan		21502	
	Physician		23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. MULTI C	ORGAN	FAI		lying, such a	is cardiac (or respiratory	arrest,		Approximate Interval Bety Onset and D	veen
	/Medical Examiner			Due to (or as a c			IC FAILU	ਬਧ						
		-	Sequentially list conditions, if any, leading to immediate	b. FULITINA			IC FAILU	KE						
	utec	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	HEPATOR	RENAL	SYNI	OROME							
Ć,	be executed sician and burial-transi	Еха	resulting in death) Last	Due to (or as a	conseque	nce of):								
3760,	Ψ - Ψ	ical	2	d. SHOCK										
P.O. Box 68	Attending Physician: The law requires that the death certificate be excludable. estor: After this certificate has been signed by the attending physician better this certificate base as the buriary the funeral director, page 2 should be detached for use as the buriary.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown	☐ Fetal d	leath 3	□Ectopic pregna □ Other (specify,				2	23d. Date of de Month		Ye ar
	res that t igned by be detact		Part II. Other significant conditio	ns contributing to death but	not result	ing in the	underlying cause	given in Par	t I.	23e. Dio	tobacco u	ise contribute t		leath?
ds	quires n sign	q p	LUNG MASS SUSPI	CIOUS OF LUNG	G CAN	ICER				1] Yes 2[□No 3 X P	robably 4 □l	Jnknowr
Vital Records,	w require been si should b	Completed by	METASTATIC LIVE							24a. Wa		24b. Were a	utopsy findings completion of c	available
Re	The larate has	E	HEIRDIKITO BIVE	It Hobelia						aun pei 1⊟ Yes	opsy formed? 2 X No	death?	· -	ause oi
ā	ician: Th certificate ector, pag		25. Was case referred to medical					26. Pla	ice of Deat	th (Check only	-			
>	ysician: is certific director,	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient	t 2 🗆 E	R/Outpatie	ent 3 DOA	Other: 4 🗆	Nursing Ho	ome 5∐Re	sidence	 6 □Other <i>(Spe</i>	ecify)	
0	g Physer this eral di		27. Manner of Death	28a. Date of Injury (Month, Day		28b. Time Injury	of 28c. l	njury at Nork?		28d. Describ	e how inju	ry occurred		
<u>0</u>	ath. r: After re funer	atio	1 Natural 5 Pending 2 Accident investig	ation			M	I∐Yes 2	□No					
Division or	after des Directo	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ry - At hom (Specify)	ne, farm, s	treet, factory, offi	ce			(Street an own, State	nd Number or F e)	ural Route Nun	nber,
_	Hospita 4 hours Funeral tely filte	Medical C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the best of Examiner: On the basis of and manner state	examinatio	riedge, dea	ath occurred at th investigation, in r	e time, date ny opinion, d	and place death occu	, and due to the rred at the time	ne cause(s e, date an) and manner a d place, and du	s stated. e to the cause(s)
	To the Hos within 24 hd To the Fun completely	Med	29b. Signature and title of certifier				29c. Lic	ense numbe	er		29d. Da	te signed (Mor	th, Day, Year)	
			► Ab	6			De	54312			06	-07-	2007)
7	2		30. Name and address of parson	on completed cause of dea	ath (Item :	23а) (Туре	e, Print)			1,27		,		
	nds		EYASU MEKONEN	900 SET	ON D	RIVE,	CUMBER	LAND M	D 215	502				
	St	ate	31. Date filed (Month, Day, Year)	20 Projetros	re Signati	IZO	porte							
	Regist	rar	JUN 0 0	ZUUT P 564	21	U. X	BAS TO							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician June PM Ewing 19 2007 2359 Albert Leon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 176 Fairview Road Elkton Cecil 8. Date of Birth (Month, Day, Year) AUG 4, 1919 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F 87 Yrs. Director 213-36-8010 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits **a**how I7 is marked other than "natural", or Itema 23a or 28a-f abov traumatic event, tre Medical Examinar must be notified at 1 ☐ Yes 2 X No Maryland Ceci1 E1kton Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 176 Fairview Road 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after ☐ Yes 2**X** No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be Health and Mental Leon V. Ewing Mabel H. Hilaman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Mary Ellen Paulette/Daughter 23 Kirks Mill Lane, North East, Maryland 21901 20b. Place of Disposition (Name of June 23, 20a. Method of Disposition 20c. Location - City or Town, State Immaculate Conception Pages nent of P 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Cherry Hill, Maryland Cemetery Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, Maryland 21921 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ung CANGE /Medical Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner been signed by the attending physician and should be detached for use as the burial-transit daath certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Cher (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 🗆 No 3 Probably 4. Hinknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? certificate Division of Vital 1 ☐ Yes 24-1No filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) ို 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.
To the Funerel Director: After 1 Natural 5 Pending Injury 2 🗌 No 1 Tes investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Contifying Physician: To the basis of my knowledge, beath occurred at the time, date and place, and due to the cause(s) and manner as etated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/20/07 H0062851 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bonni Roberts, n D.O. Kton 31. Date filed (Month, Day, Year) 32 Registrar's Signature State **JUN 2 6** Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🚄 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 5 200 Sune /Medical 4a. Facility Name (If net institution, City, Town, or Location of Death 4c. County of Death ve street and number Examiner 8. Date of Birth (Month, Day,) 9/1/1946 Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days Months Hours 15M 2 F 213-46-1258 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. In Marking Exercises 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits Director MD Rock Hall 1 ☐ Yes 2\No Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21640 Pine Ln. 21661 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced Year or Dates: Vietnam White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Auto 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecil Wilbur Foote Helen Louise George 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda J. Foote (Spouse) 21640 Pine Ln. Rock Hall, MD 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bethel Cemetery 4 Donation 5 Dother (Specify) 6/25/07 Chesapeake City, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home Aberdeen, Maryland 21001-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sa **Physician** pticemia uce disease or condition resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.O. 9 I Inknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform certificate 1□ Yes 2 PNo To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Patient 2 ER/Outpatient 3 DOA ို this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: Division 1 Natural 5 ☐ Pending investigation death. 1 Tyes 2 🗌 No 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide after within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) JUN 2 6 32. egistrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Ketta reeman 11 June 2007 2:16 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Genesis HealthCare The Pines Easton Talbot If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2 F Months Days Hours 213-42-2312 Usual Residence of Decedent Yrs. 60 Director Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show other treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Be Completed by Funeral Director Dorches 10e. Street and Number 10f. Zip Gode 10g. Citizen of What Country? 22 USA 21613 Hìgh otreet 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify 3 ☐ Widowed 4 ☑ Divorced Black "nature!" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Heelth and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Private Residence vate-Sitter a Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Freeman 1 and 2 should be otter ပ Henry John Agnes 19a. Informant's Name/Relationship 74 pe, Print) 19b. Mailing Address (Street and Number or Rural Abute Number, City or Town, State, Zip Code) Street Apt. 307-Easton, MD 21601 Warner 406-Moton Rynelle JeMeKa Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City of own, State 20a. Method of Disposition Pages Retta Department of Important: If it eny injury or o ō 1

Burial 2 □ Cremation 3 □ Removal from State Richards Mem. 6/16/07 Easton, Maryland Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility Henry Funeral Home, P.A. SIC Washington Str Cambridge MD. 21613 23a. Part I Inter the disease, or complications that caused the dead shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) -tatle Physician Metas KINO /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) cate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð 1 🗌 Yes 3 Probably 4 Unknown Be Completed 24a. Was an '24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 AMatural 5 Pending within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No М investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number completed cause of death, (Item 23a) (Type, Print) 30. Name and address of person 21601 IDLEWILD Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 10, 2007 Physician Year John Ferrillo Arthur 1:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Ft. Washington Hospital Ft. Washington Prince George's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day Year) May 4, 1928 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday, **Funeral** 117-30-4194 1**XX**M 2□ F 79 Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or itema 23a or 28a-f ehow the Medical Examiner roust be notified at 1 □ Yes 2XXNo Director Mary Land Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6913 Trowbridge Place 20744 USA e filed within 72 hours after death val Hygiene.

other then "natural", or Itema 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1월 Yes 2□No Retired If Yes, Give Year or Dates: 1982 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Lt. Colonel U.S. Air Force injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H lant: If Item 27 is marked other Arthur G. Ferrillo 1 Rosa Zozzora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6913 Trowbridge Place Ft. Washington, Maryland Inez Estalene Ferrillo / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Depertment o important: If any injury or once. Arlington Nat. Cemetery 08/16/2007 Arlington, Virginia 21. Signature 22. Name and Address of Facility George P. Kalas Funeral Home PA Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** LINKHOWY /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner istress Symbrone physicien and s the burial-transit Division of Vital Records, P.O. Box 68760, Dros 0 Physician/Medical TONA for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) sete hes been signed by the capage 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 20 No 2□ No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: Be funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗆 Yes 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manney of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending м 1 □ Yes 2 □ No within 24 hours after death. To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year) D0026242 Elvene completed cause of death (Item 23a) (Type, Print)

10 11711 Livingston Road Ft 30. Name and address of person who Samuel J. Kleiman 11711 Livingston Road Ft. Washington, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signat State

Registrar

		1 - For State Registrar	State of Maryla		artment of I		d Mental Hy	giene,	7 20587
Dhusisia		1. Decedent's Name (First, Middle, Last)					2. Date of De	aath Day Yea	3. Time of Death
Physicia /Medic		Dorisa	Mae Gull	ion			June	10, 200	0000 M
Examin		4a. Facility Name (If not institution, give si			4b. City, Town, o	or Location of De	ath	4c. County of De	eath
		Harford Memorial	Hospital			vre de G			rford
Funeral Director		220 40 3200	7. Age (In yr	s. last birthday) Yrs.	Months Days		in. 8. Date of Bir (Month, Da Nov. 9	th 9. E ly, Year) No:	Birthplace (State or Foreign Country) rth Carolina
and *		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town or Lo	ocation				10d. Inside City Limits
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. It was a read other than "natural, or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	to	Maryland Cecil		-1,,, 10111101		Deposit			1 ☐ Yes 2½GNo
n the	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
th wit	alD	204 Camp Meeting G	round Road			21904		U.	S.A.
dea	ner	11, Marital Status 1	2. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of I	Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	14. Race - Ar Black, W	merican Indian,
172 hours after death w 172 hours after death w 172 hours after must be		1 Never Married 2 Married	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	i	1 ☐ Yes 2₺ No		one mount ofer,	Specify:	
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n 72 n 72 natic	lete	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of v	vorking	16b. Kind of Busines Bata Shoe	,
iene.	Completed	Elementary/Secondary (0-12) Ten Years	College (1-4or 5+)		Inspecto			Belcamp, N	
Hyg other	Be C	17. Father's Name (First, Middle, Last)					lame (First, Middle	, Maiden Sumame)	
Med be	To B	Charles	Bare				Margie	Hester	
should and Men Men umatic		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailii	ng Address (Street	and Number or	Rural Route Numb	er, City or Town, State	a, Zip Code)
1 and 2 Health a em 27 is		Alvin D. Gullion	(Husband)	204 Ca	amp Meeti	ng Grou	nd Rd., I	Port Deposi	it, MD 21904
of He		20a. Method of Disposition		. Place of Dispo	sition (Name of matory or other pla	ce)	Date	20c. Location - City	or Town, State
Pages nent of h ant: if ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State Mt		ant Ceme		5/13/07	Colora, M	aryland
permit. Pages 1 and 2 should be filed within Department of Health and Mahall Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, the Magnes.		21. Signature of Funeral Service License	Darron		2. Name and Addre		& Son Fu	neral Home	. P.A.
		23a. Part1. Enter the disease, or complic	ations that caused the de	A. I F	erryvill	e, Maryl	land 219	03-0766	Approximate
Division	П	shock, or heart failure. List only one Immediate Cause (Final	cause on each line.	20	Myelom		nac or respiratory a	11631,	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a conse	-	70 1011				
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The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	d.	CAD						
eath certifica attending ph	/Me	IF FEMALE:	c. If yes, outcome of preg	nancy				204 Date of	
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quire n sig							1 🗆	Yes 2□No 3□	Probably 4 Unknown
w requires been si	Completed						24a. Was	an 24b. Were	autopsy findings available
hysician: The la his certificate has I director, page 2	E O						- auto	prior to death	o completion of cause of
	0	25. Was case referred to medical	/			26 Place of D	1 ☐ Yes Death Check only (es 2 No
ysici is cer direc	70 B	examiner? 1 ☐ Yes 2 ☑ No	spital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Ott	100		dence 6 □Other (Sp	necity)
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or Attending Physician: filer death. Director: After this certifica in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office	-	28f. Location (City or To	Street and Number or	Rural Route Number,
urs aft									
To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying Physi (Check only 2 Medical Examine	cian: To the best of my ki er: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the tile vestigation, in my o	me, date and pla opinion, death oc	ice, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
within 2 To the complei	Me	29b. Signature and title of confider			29c. Licens			29d. Date signed (Mo	nth, Day, Year)
- > - 0		A Ago			D006	2903		06/10/07	-
		30. Name and address of person who con	npleted cause of death (Ite	em 23a) (Type,	Print)	1			
5		ANAS ATRASH	MD 319	Suni	Δ -	Havre	De Grac	e MD 2	10.10
Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	e				

07-0 Car

)4423 ole Ann Gord	lon	Please Type or Print in Black Indelible In State of Maryland / Department of	Health and Mental Hy	giene	0505 0050
010 7 11111 0011	1	- For State Certificate of	Death	Reg. No.	2001 1000
Physici		Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day June 9, 2007	Year 3. Time of Death 1609 hrs
dical Exami		Carole A. Gordon 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		ounty of Death
		Field behind 184 E. South Street	Frederick		derick
Funeral Director		5. Social Security Number Unit 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs Months Days Hours Min	_	77YYY) 9. Birthplace (State or Foreign Country) Florida
j		Usual Residence of Decedent 10c. City, Town or Loca	tion		10d. Inside City Limits
id how any.	_	Toa. State	nswick	1	1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Flexible of the marked of the than "natural", or items 23a or 28a-f show improver in fire remainie event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Number	10f. Zip Code		n of What Country?
the N Sa or 'S	盲	301 N. Maple Ave.	21716		ted States 4. Race - American Indian, Black,
h with	eral	Armod Forces?	as Decedent of Hispanic Origin? (S Yes, specify Cuban, Mexican, Puerto		White, etc.
or its	Fun	1 Yes 2 A No	Yes 2 X No specify:	S	pecify: White
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2 hou "mat	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working life. DO NOT use re	illed)	O Homo
036 ithin 7 me. r thar	Completed	12	emaker 14% Matharia Nam	e (First, Middle, Maiden S	Own Home
21215-0036 uld be filed within 7 Mental Hygiene. marked other than event, the Medica	ပိ	17. Father's Name (First, Middle, Last)		Allen	,
121 Id be f Jental	o Be	Austin Adkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailit	ing Address (Street and Number or	Rural Route Number, City	or Town, State, Zip Code)
MD 2 id 2 shoul lith and N m 27 is m	٦	Krystal Parsley / Daughter 48	44 Pioneer Circle	, Jefferson	, MD 21755
and 2 and 2 Icalth item 2		20a, Method of Disposition 20b, Place of Disp	osition (Name of cemetery, other place)		ocation - City or Town, State
Baltimore, permit. Pages I an Department of He Important: If ite		1 Burial 2 Acremation 3 Removal from State	r Crematory 6/	14/2007 Fre	derick, Maryland
nit. Parime		4 Donation 5 Other Specify: Statific 21. Sign ture of Funeral Service Licensee 22	. Name and Address of Facility	Stauffer Fun	
Dep Dep		(outness Stauffer	1621 Opossumto	wn Pike, Fre	derick, MD 21702
Physicia		23a. Part i. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.			Between Onset and Death
'Medica kamine		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	rotic cardiovascular	disease	
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	ě	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			2.
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'60, ate be	Dhysician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			d. Date of delivery Month Day Year
687 certific	ian/	23b. Was decedent pregnant in the past 12 months?	Fetal death 3Ectopic pre Other (Specify)	griantoy	
30X death death	u ror u	1 Yes 2 No 9 V Unknown g Unknown			use contribute to the cause of death?
ords, P.O. Box w requires that the death s been signed by the att	[0	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	1 Yes 2	
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rds requi	should			autopsy performed?	prior to completion of cause of
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Vita hysici this co	ĕ ĕ	1 ✓ Yes 2 No	tient o Box	rsing Home 5 Resid	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician.			occurred at the time, date and place	and due to the cause(s) a	und manner as stated. blace, and due to the cause(s)
o the	omple	and mariner stated.	29c. License number	29d	i. Date signed (Month, Day, Year)
F * F	°	29b. Signature and title of certifier	O.C.M.E.		ne 10, 2007
		Yanua Vushall nas	J.O.IVI.E.		
		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner	111 Penn Street, Baltimor	e, MD 21201	
	- 1	Pamela E. Southall, MD Assistant Medical Examiner	_		

Registrar DHMH 17 Rev 1/2001 OCME 2006

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State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mar	yland / L	•	ificate of i		vientai n	ygierie Reg. No	2 11	2000)
	Physicia		1. Decedent's Name (First, Middle, Last,						2. Date of D	Death Da	ıy Year	3. Time of Death
Ť	/Medic	-	Robert James Grabenste							ne 03,	2007	09:10 A M
	Examin	er	4a. Facility Name (If not institution, give			4	4b. City, Town, or	Location of Death		1	County of Dea	th
دينان		, j.	WMHS - Braddock Carr 5. Social Security Number 6. Sec		(In yrs. last bir	thday)	If Under 1 Year	Cumberlan If Under 24 Hrs.	8. Date of B	lirth	Allegany 9. Bir	thplace (State or Foreign
	Funeral Director		215-38-9317	≰ M 2□F		Yrs.	Months Days	Hours Min.		Day, Year il 07, 1	C	aryland
	land ow It		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Tow	n or Loca	ition					10d. Inside City Limits
	Mary t-f sh fled a	to	Maryland Allegan	y	Frostbu	ırg						1 Yes 2 No
	or 28% e not	Director	10e. Street and Number 228 East	Main Street			10f. Zip Code			10g. Ci	tizen of What Co	ountry?
	23a ust b						21532-			U.S		
	er dea items ner m	Funeral		12. Was Decedent Ev Armed Forces?		13. Wa	as Decedent of H Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No Rican, etc.)	10-	14. Race - Ame Black, Whi	
36	rs afte		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	fYes 2 □ No IfYes, Give V Year or Dates:		1 🗆	Yes 2 No	Specify:			Specify:	hite
Ş	2 hou atura ical E	ted	15. Decedent's Edu	cation	War 16a.	Deceder	nt's Usual Occup	ation	delm m	16b. h	Kind of Business	
212	be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)				during most of wor t)	King			
2	Hygien Hygien ther th	S)	n	naster	sergeant	40 Mathada Nas	/Fi4 & district		S. Army	
Maryland 21215-0036	be be	Be	17. Father's Name (First, Middle, Last) Peter Grabenstein					18. Mother's Nan Delores N		ie, Maide	n Surname)	
ž	s 1 and 2 should be: f Health and Mental item 27 is marked o other traumatic eve	၉	19a. Informant's Name/Relationship (T)	pe. Print)	195	. Mailing	Address (Street	and Number or Ru		nber, City	or Town. State.	Zip Code)
	5 = 2 T	H	Linda McKenzie	daughter		_	berry Lane		rostburg		Maryland	21532-
ē,	ges 1 and 2 t of Health If item 27 or other tr		20a. Method of Disposition				tion (Name of atory or other place		Date	20c. l	ocation - City or	Town, State
Ë	Pages nent of int: If its iry or o		1 ⊠Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State			l's Cemeter		me 05, 2007	Fro	stburg N	Maryland
Baltimore,	permit. Pag Department Important: I any injury o	j	21. Signature of Funeral Service Licens	Way t	_		Name and Addre	ss of Facility ral Home, 57	Frost Ave	· Fro	sthuro MD	21532
			23a. Part: Enter the disease, or completion, or heart failure. List only o	ications that caused th	ne death. Do						, 141D	Approximate
	Physician		Immediate Cause (Final	ne cause on each line Liver								Interval Between Onset and Death 1 Week
	/Medical		disease or condition resulting in death)	Due to (or as a								1 week
	Examiner		Conversation link and distance	Metasta	atic S	Smal	.1 Cell	Carcin	oma			4 weeks
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	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence	of):						
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68760,	tificate be executed ig physician and as the burial-transit	edical		d								
_			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pl		ه ⊐ح					23d. Date of de	elivery
Ď	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2 4□Pregnant at ti			Ectopic pregnancy Other (specify) _	<i>y</i>		.	Month	Day Year
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Vital Records, P.O. Box	The law requires that the death cer ate has been signed by the attendin bage 2 should be detached for use	by	Part II. Other significant conditions co	ntributing to death but	not resulting i	n the und	lerlying cause giv	en in Part I.		A		o the cause of death?
ord	requil een s hould	ted									943	robably 4 Unknown
ခွင	has by	Completed							24a. Wa	topsv	24b. Were a prior to death?	utopsy findings available completion of cause of
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₹	Physician: The la r this certificate has ral director, page 2	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/O	utnotiont	3 DOA Oth	er:			6 □Other (Spe	
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Ö	Attending Physician: r death. ector: After this certifica by the funeral director, I	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	rear)	Injury		Yes 2 □ No				
Division or	or Attencatter death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury building, etc.	y - At home, fa (Specify)	arm, stree	et, factory, office		28f. Location City or 1	(Street a	and Number or F te)	lural Route Number,
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: . completely filled in by the f	Medical		sician: To the best of iner: On the basis of a and manner state	examination ar							
	Fo the within Fo the complex complex	Me	29b. Signature and title of certifier	111			29c. Licens	e number		29d. D	ate signed (Mor	th, Day, Year)
)	15/1VA) () / /	100			DO	023371		Ju	ne 5,	2007
	15/10H		30. Name and address of person who c							1		
	nas		Qamar Zamar			ent	Avenue	e, Cumbe	erland	, Ma	aryland	21502
	Sta	te	31. Date filed (Month, Day, Year) 7 2007	32. Registrar	's Signature	base	6.					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jun 8 **Physician** 12:44 PM MADELINE GAGE 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREENBELT
If Under 1 Year | If Under 24 Hrs. 8565 GREENBELT RD. #T-3 PRINCE GEORGE'S

9. Birtholace (State or Foreign 8. Date of Birth (Month, Day, Year) JUNE 18, 1 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F Months Days Hours Min 215-57-5654 70 Director 1936 LIBÉRIA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 √Yes 2 No Director MD PRINCE GEORGE'S GREENBELT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8565 GREENBELT RD. #T-3 20770 LIBERIAN Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: BLACK Completed by Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC DOMESTIC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL GAGE PLEH MYANTEE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MATTYMAI DAVIS/DAUGHTER #T-3 GREENBELT, MD. 20770 8565 GREENBELT RD.. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 DRemoval from State PARKLAWN CEMETERY 4 □ Donation 5 □ Other (Specify) 6/16/07 BRENTWOOD, MD. 21. Signature Funeral Service License 22. Name and Address of Facility 20002 CAPITOL MORTHARY 1425 MARYLAND AVE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. omplications that caused the death. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-transi and Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 mon 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy 2 X No 2XXXI 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 1 Inpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner Death 28b . Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitai or

To the Hospital within 24 hours a To the Funeral C Medical

Baltimore, Maryland 21215-0036

P.O. Box 68760.

Division or Vital Records,

State Registrar

Year) 31. Date filed (Month, Da) 2007 JUN 1 2

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ess of person

29a. Certifier

30. Name and



completed cause of death (Item 23a) (Type, Print)

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Juste 357

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2007 Month **Physician** June 19, Thi Hoang 2:15 P M Knam Lang /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 13111 Flintrock Beltsville Prince George's Drive 8. Date of Birth (Month, Day, Jan. 19, 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** 1924 Months Days Hours 1 □ M 2 🗓 F Jan. 83 Vietnam 216-45-4028 Director Laos, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic excessions. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Directo Maryland Prince George's Beltsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20705 Vietnam 13111 Flintrock Drive Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 ☑ No Specify þ 3X Widowed 4 □ Divorced Asian Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Thu Van Hoang 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13111 Flintrock Beltsville, Maryland 20705 Dr., David Vinh, son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State June 22, 2007 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Donald V. Borgwardt Funeral Home, P.A. 4400 Powder MIII Road, Beltsville, MD 21. Signature of Funeral Service Licenses 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final months Colorectal Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the burial-trans attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ /n Completed

Physician /Medical Examiner

funeral

law requires that the death certificate be execu

To the Hospital or Attending Physician:

within 24 hours To the Funeral

Division or Vital Records, P.O. Box 68760,

		1 Yes 2 No 3 Probably 4 Unknow
		24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Dea	ath (Check only one)
examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	Home 5 XResidence 6 □Other (Specify)
27. Manner of Death 1		28d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Ph	ysician: To the best of my knowledge, death occurred at the time, date and place	e, and due to the cause(s) and manner as stated.

145014

29b. Signature and title of certifier > Befelle

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 200

20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8343 Cherry Lane, Laurel, Maryland 20707 Isabella C. Martire MD

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 **Physician** June 19 0950 A^{M} William Turner Hilaman, Jr. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Ceci1 347 Chrome Road Rising Sun If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F OCT 8, Director 212-38-4686 1940 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕱 No item 27 is marked other than "natural", or Items 23a or 28a-f st other traumatic event, the Medical Examiner must be notified Funeral Director Maryland Ceci1 Rising Sun 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 347 Chrome Road 21911 United States death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Automobile and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Assembler Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f nent of Health and Mental I William T. Hilaman, Sr. Julia M. Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important; if item 27 is: any Injury or other trau Dorothy Hilaman/Wife 347 Chrome Road, Rising Sun, Maryland 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 25, 1 L Burial 2 □ Cremation 3 □ Removal from State Rose Bank Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Calvert, Maryland 22 Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 Signature of Funeral Service 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Due to (or as a obsequence of): Cancer disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last neuno Due to (or as a consequence of) Examine The law requires that the death certificate be executed COPP ig physician and as the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy jo in the past 12 months? Month Dav 4☐Pregnant at time of death signed by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760, Division or Vital Records, To the Hospital or Attending Physician; nours after death.

neral Director: After this ce
filled in by the funeral direc within 24 hours a

To the Funeral C

completely filled

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State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

West

and manner stated

CHIH 141) 223 31. Date filed (Month, Day, Year)

Du cuil Han MD

. Registrar's Signature JUN 2 6 2007

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D04823

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

John P.

31. Date filed (Morth, Day, Year)

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JUN

M.D.

2007▶

32. Registrass Signature

1920 Solomons Island Rd., Huntingtown, MD

To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number IZIT MO 218015

29b. Signature and title of certifier

JUNE 13, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO 340 DATTA VASATT

21740 HAKERSTOWN MD

State Registrar

Medical

31. Date filed (Month, Day Year) 3 2007

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0050M emue /Medical 4b City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WICOMI The Jalisbur CLO If Under 1 Year | If Under 24 H 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 994 Months: 1 M 2 □ F Director Usual Residence of Decedent iit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hygiene. Partirent of Health and Mental Hygiene. Partirent if Item 27 is marked other than "natural", or items 23a or 28a-f show britant if Item 27 is marked other than "health are well, the Medical Examiner must be notified at Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 yes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☑ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WOR Kci 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 0 19a. Informant's Name/Relationship (Type. PrInt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ó MOOSE (granddoug Hammon Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Con 22. Name and Address of Facility Signature of Funeral Ser or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the diseas shock, or hear failure. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 Tyes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has I page 2 performer: 1□ Yes 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical examiner Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral. 28a. Date of Injury 28b. Time of 27 Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cocaster OUG 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2007

DHMH 17 Rev 1/2001

		State of Maryland / Departm	nent of Health and Moate of Death		0113	
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Division of Vital Records, P.O. or or Attending Phyeicien: The law requires that the datter death. Director: After this certificate has been signed by the tine tuneral director, page 2 should be detached.	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Stree City or Town, S	et and Number or Ru State)	ral Route Number,
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Phyeician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier Certifying Physicien: To the best of my knowledge, death occu	urred at the time, date and place,	and due to the caus	se(s) and manner as	stated.
the Hc hin 24 I the Fu mpletel	Medical	(Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation and manner stated.	ation, in my opinion, death occurr	red at the time, date	and place, and due	to the cause(s)
To the within To the common co	Σ	29b. Signature and title ol certifier	29c. License number		. Date signed (Month	
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		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael Fitalchen WW 302 Cc//	ine Hunton	k md	2164	2
S	ate	31. Date filed (Month, Day, Year) 2007 31 Registrar's Signature	-03 //001100	,	- , - /_	
Regis	trar	JOH T 9 TOOL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 06 Physician Year 07 Richard House 0900 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS Braddock Campus Allegany Cumber1and If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 29, 1922 5. Social Security Number 6 Sav 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1□M 2□F MD 217-14-4184 85 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location a or 28a-f show be notified at 10d. Inside City Limits MD Allegany Cumberland Y□Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 'natural", or items 23a o 11900 House Drive USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23s iny or other traumatic event, the Medical Examiner must iny or other traumatic. by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. Yes 2 No
If Yes, Give
Year or Dates: WWII 1 ☐ Never Married Ž ☐ Married 1 ☐ Yes 2 🕍 No Baltimore, Maryland 21215-0036 Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) laborer Celanese Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **Erven House** Cleo Evangeline Wilson House ည 19a. Informant's Name/Relationship (Type. Print)
Shirley House 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11900 House Drive Cumberland MD 21502 wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Sunset Memorial Park 6/11/2007 Department of Important: If any Injury or once. MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer & Septice Licenses 22. NameScandelli Puliella Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 101 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or sela consequence of): Examiner The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was a. autopsy performed? Yes 21XNo 2□ No 1 TYes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide e Funeral I 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2. the

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State JUN 0 8 2007 Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and itle of certifier



29c. License number

DOO 18216

29d. Date signed (Month, Day, Year)

6-8-07

vive Cumberland Haryland 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended itef = state #26, per physician, 6/12/07, Certificate of Death B.A. WCHD 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 7:59 PM Sung Im 2007 6 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester 101 Pine Forest Dr. Rerlin If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dav. Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕅 F Yrs 73 10/17/1933 North Korea Director 547-64-4271 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes 2√ No r than "natural", or Items 23a or 28a-f sh the Medical Examiner must be notifiled Director Browns Mills NJBurlington 10g, Citizen of What Country? 10f. Zip Code 10e Street and Number 1478 Junction Road Apt. #1507 08515 USA 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: <u>م</u> 3 Widowed 4 Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. Packaging Company Line Worker 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Park Soon Han ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 101 Pine Forrest Dr., Berlin, MD 21811 Jennifer Klepper 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Tremation 3 ☐Removal from State 6/14/2007 4 ☐ Donation 5 ☐ Other (Specify) Allied Crematory Bensalem, PA 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, MD 21811 at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the disease, or complications thock, or heart failure. List only one au Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-trans and Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the SS IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Dav 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 21 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 20 No 24a. Was an autopsy certificate Secondary 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Hesidence 6 MOther (Specify) Pesidence 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို this 27. Manner of Ca funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 ne Hospital or An.
hours after death.
al Director: After
hy the fur Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifier Medical

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within 2

State Registrar

29b. Signature and title of certifie

30 Name and address of person

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31. Date filed (Month, Day,

and manner stated.

ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** 12:32 PM 14, 2007 June Theresa A. Jelacic /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Annapolis, MD Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9/28/1917 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖫 F Benwood, 89 Director 233-03-6233 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State r 28a-f show notified at 10b County 1 ¥Yes 2 No Benwood Director WV Marshall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? s 1 and 2 should be filed within 72 hours after death with the leath and Mental Hygiene. "naturai", or items 23a or adleai Examiner must be r USA 26031 141 Roosevelt Avenue Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, GiveX Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo White Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medicai Elementary/Secondary (0-12) College (1-4or 5+) ABCC Commission 12 retired manager 7 is marked othe traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Matesic Andrew Skoda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2542 N. Haven Cove, Annapolis, MD 21401 John Jelacic item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Valley Crematory 6/18/2007 Bellaire, OH 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lic Altmeyer Funeral Home, 118 Grant Ave. 711 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

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Interval Between
Onset and Death Immediate Cause (Final days **Physician** Phenmonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): attending physician for use as the burial pe Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown he 9 □Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has page 2 s autopsy 2 No certificate 1☐ Yes Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📆 No 1 Inpatient 3□ DOA 2 ER/Outpatient After this 은 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: ospital or Attending hours after death. 5 ☐ Pending investigation 1 Natural Injury within 24 hours after deam.

To the Funeral Director: After the funeral on by the funeral process. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitai 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Mrerd Bah, ous 6/14/07 D46052

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Saltimore, Maryland 21215-0036

Box 68760,

P.O. |

Division or Vital Records,

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Siveral Blike, MO

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
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32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Рм lohnson 200 idith /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5. Social Security Number 04 Certer irthday) If Under 1 Months Maryland Medical baltimore 8. Date of Birth (Month, Day, Year) **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Min. 1 □ M 2 🗙 F Hours Director PENNSYLVANIA FEB.11,1941 163-32-3294 66 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2📆 No Director CENTREVILLE MD **OUEEN ANNE** 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21617 119 OVERTURE WAY Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 📆 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. WHITE Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BUSINESS OWNER MEDICAL BILLING 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LAWRENCE ALLEN 2 THERESA MARIACHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 OVERTURE WAY, CENTREVILLE, MD 21617 19a. Informant's Name/Relationship (Type. Print) STEPHEN JOHNSON/ HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important; If any Injury or CHESAPEAKE CREMATION 6-13-07 STEVENSVILLE, MD 21666 4 □ Donation 5 Other (Specify) CENTER 22. Name and Address of Facility 21. Signature of Juperal Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complication at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one case on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Kespiraton tailure 3days /Medical Due to (or as a consequence o) **Examiner** fail Cenal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine The law requires that the death certificate be executed Hypertensive bleed Dubb (or as a consequence of): physician and s the burial-trans Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph for use as t IF FEMALE: 23c If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed' To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA မ this funerat 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death filled in by the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11mp P1890 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of Maryland Medical Center, Baltimore Ha Lowersit 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Marylan	_			Mental Hyg	giene		
			Registrar		Ce	rtificate of l	Jeath		Reg. No.	7 20501	
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	/Medic	al	Kuby 1. J	Ohrson		т		06	12 01	0250 AM	
	Examin	er	4a. Facility Name (# not institution, give si	reet and number)	4b. City, Town, or	Location of Deat	h	4c. County of De			
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	/land		10a. State 10b. County	10c, City	, Town or Lo	ocation		-		10d. Inside City Limits	
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	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?	
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	ems er mi	Funeral	11. Marital Status	Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, W	nerican Indian, nite, etc.	
98	or It	Y.	1 Never Married 2 Married	1 ☐ Yes 2 【XNo If Yes, Give		1 ☐ Yes 2 ☐ No	Specify:		Specify: \	white	
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Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene if the file 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	Walton E. Townsend	l			Eva T.	Hickman	1		
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Baltimore,	permit. Page Department of Important; If any injury or once.		21. Signature of Funeral Service License	е	2	Name and Addre	Funeral	Home Pro	fessional City, MD	Association	
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Вох	atter for u	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		□Ectopic pregnanc: □ Other <i>(specify)</i> _	У		Month	Day Year	
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ita	Iclan: The certificate ector, pag	BeC	25. Was case referred to medical examiner?			10-20	26. Place of De	eath (Check only o	ine)	1	
<u>-</u>	Physic this ce al direc	은	1 Yes 2 No		ER/Outpatie		4 LI Nursing	Home 5 ☐ Resi	dence 6 □Other (S	pecify)	
n c	Ing I		27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	Wor		28d. Describe	how injury occurred		
Sio	tendleath.	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 □ No	000 1		D -10- 1- 11	
Division or Vital Records,	l or At after d Direc J in by	Certification:	4 ☐ Homicide determined	28e. Place of injury - At h building, etc. (Special	ome, rarm, s fy)	treet, ractory, office		City or To		Rural Route Number,	
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	edical Co	(Check only 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina							
	thin 2.	Medi	one) 29b. Signature and title of certifier	and manner stated.)	29c. Licens	se number	,	29d. Date signed (M	onth. Day, Year)	
	N N N N N N N N N N N N N N N N N N N	_	() ()) () E	Colon In	1)	1	247	78			
			30. Name and address of person who co	impleted cause of North /tra	n 22a) (Turo	Print)	000	, 9	0 / 2		
	BAID		DAVIDE. COUPLY,	MO COASTAL;	HSP14	E POL	50× 17	33 5	ALICBURY,	-07 WS 2/8/2	
3	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 1 3 20	32. Registrar's Signa	A A	porte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Mary Patricia Jackson JUNE 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Magnolia Nursing Center Lanham Prince George's 8. Date of Birth (Month, Day, Year) Feb. 29, 1944 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months 63 Washington, DC 577-58-2882 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Maryland Prince George's Brandywine Director 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10712 Cedarville Road 20613 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 K Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Nanny Child Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ferdinand Phillip Jackson Frances Goodman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Judith Bauer 10712 Cedarville Road Brandywine, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 11,2007 Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician aranomh Breast with metastoos to bove disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of:

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Saltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Medica

State Registrar

lical E	resulting in death) Last	Due to (or as a consequence of):								
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year							
þ	Part II. Other significant conditions of	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown								
Complet		24a. Was an autopsy performed								
Certification: To Be Completed b	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hom	(Check only one) e 5 ☐ Residence 6 ☐ Other (Specify)							
	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Solution 1 28c. Injury at Work? M 1 Yes 2 No	Bd. Describe how injury occurred							
	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a Cartiflar 1 artifuing Ph	revisions. To the best of my knowledge, death accurred at the time, date and place, a								

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DO1852

QUEENSBURY ROLHIAL HOW IN MD 20781

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, Year JUN 1 2 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OREMD 4203

32. Registrar's Signat

			State of Maryland / Department of Health at Certificate of Death	ınd Men	, ,	ene g. No. 0 0	7	20	60
(4)	6. *	-	Registrar 1. Decedent's Name (First, Middle, Last)		Date of Death		· :	3. Time	of Death
	Physicia	_	Willie Major Johnson		Month une	9, 2007	ear	1:	20a ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of	f Death		4c. County of I			
	Examili		Forestville Rehab. & Healthcare Ctn. Forestville			Prince	Geo	rge	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2	24 Hrs. 8. [Min. (Date of Birth Month, Day,	Year) 9.	Birthplac Country	e (Stat	e or Foreign
	Director		227-66-2787 12 M 2 F 57 Months Days Hours	Ap	ril 13	, 1950	Virg		a
	pu ,		Usual Residence of Decedent 10a State 10b, County 10c, City, Town or Location				104	Incido	City Limits
	aryla shov d at	_	2 1 1				100		es 2 No
	he M 8a-f otifie	Director	Maryland Baltimore Baltimore		10	g. Citizen of Wha	t Country		
	with the ben					nited St			
	sath is 23	Funeral		nin? (Specify		14. Race			
	Item Item	Š	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Married	, Puerto Rica	in, etc.)		White, etc		
<u> </u>	irs af	þ	3 □ Widowed 4 \(\) Divorced If \(\forall e \) or Dates: 1/11/72 1 □ Yes 2 \(\) No Specify:			Specify:	Blac	k	
15-0036	2 hou	ted	15 Decedent's Education 16a. Decedent's Usual Occupation	t of working	1	16b. Kind of Busin	ess/Indus	stry	
212	hin 7 an "n Medi	e e	(Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+)	Or WORKING					
7	d wit	Completed	12 4 Social Worker			Health C	are		
p	al Hy d oth	Be		•		faiden Surname)			
<u>a</u>	Ment arked	2	Unknown Lucy	E11		ohnson			
Maryland 2	2 sho and is m		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number					ode)	
2	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Frances Carter / Sister 3201 Neal Street R	ichmon Date		ginia 23 20c. Location - Cit		- State	
Ö			1▼ Burial 2 □ Cremation 3 □ Removal from State				•		
Baltimore,	t. Pa rtmer rtant:		The second control of	06-15-0		Richmond	, VI	Tg1.	ша
g	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee Pope Funeral Ho 5538 Marlboro I	omes, Pike F	P.A.	ville. Ma	rv1.a	ınd	20747
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a shock, or heart failure. List only one cause on each line.				A	nixoraq	
	Physician		Immediate duse (Final CTDOVE				Ö	onset ar	nd Death
	/Medical		disease or condition resulting in death) STRUKE Due to (or as a consequence of):				_		
	Examiner		HYPERTENSION						
	7 ==	ner	Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events						
	nd transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
8760,	ate be executed hysician and the burial-transit	Ě	resulting in death) Last Due to (or as a consequence of):						
	cate be executed physician and the burial-transit	dical	d				+-		
9 X	The law requires that the death certific: tte has been signed by the attending pl bage 2 should be detached for use as t	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date	of delivery	,	
ROX	atten for u	cian	in the past 12 months? Continue of the past 12 months Continu			Month		ay	Year
o.	at the de by the tached	iysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown						
J.	that ned by deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	. []	23e. Did tob	acco use contribu	ite to the	cause	of death?
Vital Records,	w requires been sign should be	d by	MYOCARDIAL INFARCTION	:	1	es 2∐No 3∣	☐ Probab	oly 4	Unknown
000	s bee	Completed			24a. Was ar	n 24b. We	re autops	y findin	gs available
Re	sician: The law certificate has t irector, page 2 s	шо			autops perforn 1 Yes 2	ned? dea	r to comp th? Yes 2		of cause of
ā		Be C		of Death (C	heck only on				
	Physic this ce	To B	examiner? 1 Yes 2 No	rsing Home	5 🗆 Reside	ence 6 Other	(Specify)		_
0	ng Pt fter tt neral	ü	27. Manner of Death 28a. Date of Injury 1 ☐ Natural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?			w injury occurred			
<u>S</u>	Attendia death. ctor: A y the fu	atic	2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ N						
Division or	il or Attending Patter death. Director: After it in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f.	Location (St. City or Town	reet and Number n, State)	or Rural I	Route N	lumber,
	Hospital of the safe of the sa		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date an	nd place, and	due to the ca	ause(s) and mann	er as sta	ted.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, I	edical	((Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea and manner stated.						se(s)
	To the Hos within 24 hd To the Fun completely	Me	29b. Signature and title of certifier 29c. License number		2	9d. Date signed (r)
)			D 515	20		6-18	1-(17	
0	73/11		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		•				
1		l	BAHRAM PISHDAD, MD. 1328 SOUTHERN AVE., #310 WASH	IINGTON	D.C.	20032			
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature						
	Registi	ar	I IUN I Z CUVI PACILIO PACI						

DHMH 17 Rev 1/2001

	1 - For State Registrar	State of Maryland		ent of Health ate of Death	ל		ene () () 7	206		
Physician /Medical Examiner	Decedent's Name (First, Middle, Last) Raymond Warner Klo 4a. Facility Name (If not institution, give s		4b. Ci	ty, Town, or Location	J	Month June 14	Day 2007	Year of Death	3. Time of 2:38		
Funeral Director	42 Klotz Drive 5. Sociat Security Number 6. Sex		McH	lenry	er 24 Hrs. R	Date of Birth (Month, Day,)	Garre	tt 9. Birthp	lace (State of try) 7 1an d	r Foreigr	
	Usuat Residence of Decedent 10a. State 10b. County	10c. City	Town or Location						0d. Inside Cit		
if Health and Mental trygiene itam 27 is marked other than "natural; or itame 23s or 28s-f show other traumatic event, the Madical Exercities rotation at To Be Completed by Funeral Director		2. Was Decedent Ever in U.S. Armed Forces? 1			an, Puerto Rican, etc.) Black, Whit			e - Americ k, White,	an Indian, etc.		
ygiene. her then "natural t, the Mardical E.	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates: ation completed) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired) Dairy Farmer				White 16b. Kind of Business/Industry Dairy Farming			dustry		
marked oth marked oth imatic event To Be (17. Father's Name (First, Middle, Last)	pe, Print)	19b. Mailing Addre		n Beit	zel	n, Maiden Sumame)				
Depertment of Health and Importent: If item 27 is many injury or other traum once.	Wesley L. Klotz/Sol 20a. Method of Disposition 1	emoval from State Cra	42 Klotz ace of Disposition (familiary) or ontsville	Dr., McHe	enry, MI Date June 18	2154	oc. Location - Grant	City or To	wn, State)	
physicien end the burial-transit	Immediate Cause (Finat disease or condition resulting in death) Sequentiatly list conditions, if any, leading to immediate cause. Entire Undergraph Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									Death	
ed by the attending phydetached for use as the Physician/Medic		3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	23d. Date of delivery Month Day Year			fear					
s been sign 2 should be pleted by											
s certificete hes director, page 2 :	25. Was case referred to medical examiner? 1 Yes 2 Cher Hospital:							topsy prior to comptetion of cause of death? 1 Yes 2 No			
within 24 hours after death. To the Funeral Director: After this certificete he completely filled in by the funeral director, page. Medical Certification; To Be Com	1 165 2 1 10	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At he building, etc. (Specify	28b. Time of Injury M	28c. Injury at Work?		rising Home 5					
within 24 hours a To the Funeral I completely filled Medical Ce	29a Certifier 1 Certifying Physics (Check only one) 1 Medical Examination	sician: To the best of my knother: On the basis of examinal and manner stated.	tion and/or investigati	ed at the time, data on, in my opinion, de	eath occurred a	at the time, dat	e and place,	and due to	the cause(s)	
(4) State	30. Name and address of person who co	mpleted cause of Seath Hemilians 32. Rediktrar's Signa	29	144160	exre T	TM	CHen) - (MJ	>	

		-	For State Registrar	State of Mar		partment of H e <i>rtificate of L</i>			JIENE Reg. No.		
ľ	Dhysisi		Decedent's Name (First, Middle, Las	t)				Date of Dea Month		Year	3. Time of Death
	Physicia /Medic	al	DAR			LYONS		06	18	07	0140 ^M
	Examin	er	4a. Facility Name (If not institution, give WMHS BRADDOC			4b. City, Town, or CUMBEI	Location of Death			y of Death LEGAN	
	Funeral		5. Social Security Number 6. Se		In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	1	9. Birth	nplace (State or Foreign
М	Director			MM 2□F	84 Yrs.	Months Days	Hours Min.	(Month, Day July 10		Cot	k Garden, WV
	pu. »		Usual Residence of Decedent 10a. State 10b. County	1	0c. City. Town or	Location					10d. Inside City Limits
	f shoved at	ō			,,						1 □Yes 2 X No
	the N 28a-	Director	WV Mineral 10e. Street and Number		Nev	V Creek 10f. Zip Code			10g. Citizen of	What Co	untry?
	h with		HC 75, Box 33-A			2674	3			USA	
	r deat	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13	3. Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Ra		rican Indian, e, etc.
36	72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give		1 ☐ Yes 2 🛣 No	Specify:		Spec	ifv	
0	tura!		15. Decedent's Ed	Year or Dates: To		cedent's Usual Occup	ation		16b. Kind of I		hite Industry
215	within 72 ene. than "na the Medic	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	life	ve kind of work done o . DO NOT use retired	during most of work l)	king			•
21	filed wit Hygiene other tha	Com	8			Coal Miner				al Mi	ning
pu	be fill tal H d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			me)	
Σğ	2 should be and Mental is marked (aumatic ev	ဍ	Isaac Newton Ly 19a. Informant's Name/Relationship (1)		19h Ma	uiling Address (Street a		Wilson		n State 7	Zin Code)
Ma	nd 2 suith an 27 is r trau		Robert D. Grapes/			4, Box 52		yser, W	•		
re,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygene. If item 27 is marked other than "natural", or items 23a or 28a-f show it item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	•	20b. Place of Dis	position (Name of rematory or other place		Date	20c. Location		Town, State
im	Pages ment of l ant: If its ury or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		-	h Cemetery	200		Elk (Garde	en, WV
Baltimore, Maryland 21215-0036	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licen	of it	-	22. Name and Addres	OII.	ith Fun			
	2020		23a. Part1. Enter the disease, or com	plications that caused th	ne death. Do not e	85 S. Ma:			er, WV	26	726 Approximate
L	Physician /Medical Examiner		shock, or heart failure. List only	one cause on each line.		20		o			Interval Between Onset and Death
			disease or condition resulting in death)	a. Due to (or as a	consequence of):	Of LUN	9			_	Lomonths
			Sequentially list conditions	b							
7	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):						
N.	xecute and Il-tran	Examiner	that initiated events resulting in death) Last	cDue to (or as a	consequence of):						
68760,	ficate be executed physician and is the burial-transit	Sal									
		ledical									
Вох	eath certif attending for use as	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf 1 Live birth 2		3□Ectopic pregnancy	/			ate of del	
	The law requires that the death cert te has been signed by the attending tage 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at tir 9□Unknown	me of death	5 ☐ Other (specify) _	-			Month	Day Year
P.0	that the dened by the a		Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use co	ntribute to	the cause of death?
or Vital Records,	quires n sign	d by						112	Yes 2 □ No	3 □ Pr	obably 4 □Unknown
900	law requir as been si 2 should l	Completed						24a. Was	an 24t). Were au	topsy findings available
R	The la	mo;						autor perfo 1□ Yes	rmed? 2 1 No	death?	completion of cause of 2 ☐ No
/ita	Physician: The rhis certificate ral director, pag	Be (25. Was case referred to medical examiner?	Hara Sala		la.	26. Place of Dea	th (Check only o	ne)		
or/	Phys this al dir	မ	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 ☑ Inpatient 28a. Date of Injury	2 ☐ ER/Outpat		4 LI Nursing H	ome 5 ☐ Resident			cify)
	ding I. Aftel fune	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day		y Wor	yat k? Yes 2∐No	zou. Describe i	now injury occ	ired	
Division	or Attending ufter death. Director: After in by the funer	ifica	3 Suicide 6 Could not be determined	28e. Place of injury		street, factory, office				nber or Ri	ural Route Number,
Ö	Ital or rs afte rai Dir	Certification:	4	building, etc.	(Specify)			City or To	vii, State)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical		ysician: To the best of niner: On the basis of e and manner state	examination and/o						
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and marrier state		29c. Licens	e number		29d. Date sign	ned (Mont	th, Day, Year)
	->-0		> 7/_	for-		Do	033280		June	_ (6	,2007
	8		30. Name and address of parson who	completed cause of dea	ath (Item 23a) (Typ	pe, Print)	0				
			DR SUNL GU 31. Date filed (Month, Day, Year)	Ota Load	5 Kent	HUENIUE	Cumi	perlar	din	10 c	X150a
	Sta Regist		JUN 2 6 200	17 Merse	B A	AVENUE					

State of Maryland / Department of Health and Mental Hygiene

		1	For State Registrar	State of Marylar		rtificate of E	Death		eg. No.	187	2.116	115
	Dhysisis	1. Decedent's Name (First, Middle, Last)			_		2. Date of Dear Month	Day	Year	3. Time of Dea	ath M	
35 485	Physicia /Medic	al 👢			add,	Sr.	Leasting of Dooth	June 3,		1:30		
	Examin	er	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or Dunk				lvert		
			458 Jewell Road 5. Social Security Number 6. Se	7. Age (In yrs.	. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			place (State or Fo	oreign
b	Funeral Director			OM 2□F 75	Yrs.	Months Days	Hours Min.	Jan. 1	7,1932		rginia	
	pu ,		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City L	imits
	shov shov ed at	.	MD Calve		Dunl						1 □ Yes 2	No No
	the N 28a-f	Director	10e. Street and Number 10f. Zip Code						10g. Citizen of What Country?			
	3a or	Ö	458 Jewell Road			2075	54		U	.S.A.		
	death ms 2 r mus	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bl	ace - Ameri ack, White		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 No If Yes, Give Year or Dates 1951 -		1 □ Yes 2 No			Spec	cify: W	hite	
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≥, ≤	and lealth m 27 her tr		Teresa M. Ladd,			Jewell Rd.		Date	20754 20c. Location	n - City or T	Town, State	
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	nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Data to for up a period								
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O. E	ie dea the at hed fo	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time o 9□Unknown	of death 5	Other (specify)						
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, de nination and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occ	e, and due to the urred at the time	cause(s) and , date and pla	d manner a ice, and du	s stated. e to the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and mainter stated.		29c. Licen	se number		29d. Date si	gned (Mon	th, Day, Year)	
	F M F 8		n dhi	malla.	m l	D	1777	14	6,	410	7	
	_		30. Name and address of person who	completed cause of death (Item 23a) (Typ	e, Print)					0	,
_	15+1		MAHIN YAZ	LDANI P.U	BOX	370 h	HUNTIN	600V	N	M	D 200	539
	S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrate Si	ignature	1.00						

State Registrar

JUN 1 2

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JUNE 1²3, 2007 9:25A.M. **Physician** ALLEN WALTER LAWSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON BOONSBORO REEDERS MEMORIAL HOME If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 □ F MARCH 9, 1923 NEW YORK Director 066-18-5724 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director BOONSBORO WASHINGTON MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21713 21101 KEADLE ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 By Yes 2 □ No 1943-If Yes, Give Year or Dates: 1946 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: ME:LAWSon, WALTER Baltimore, Maryland 21215-0036 Specify: þ WHITE 1946 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) ORCHESTRA 4 MUSICIAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ALICE E. ALLEN FRANK B. LAWSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13202 FAIRFAX ROAD, HAGERSTOWN, MARYLAND 21742 BRUCE A. LAWSON/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) SMITHSBURG CREMATORY: 6/14/2007 SMITHSBURG, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7606 Old National Pike BAST FUNERAL HOME Paul M.Dean Boonsboro, Maryland 23a, P rt1. Enter the disease r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Artio Condito Vanal Schooling **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Clause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 100 10 certificate 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death Certification: (Month, Day Year) 5 Pending investigation 1 C Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 (Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JUNE 13, 2007 and mo D18019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VASANT DATTA, 340 MILL STREET, HAGERSTOWN, MARYLAND 21740 301-739-7100 041-15+1 32. R gistrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

2007

JUN 14

Certificate of Death

2. Date of Death

3. Time of Death

1. Decedent's Name (First, Middle, Last)

Division or Vital Records, P.O. Box 68760. detached To the Hospital or Attending Physician:

Day **Physician** Month Catherine Leasure 10, 2007 2:10 A M June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ner Lions Ctr. for Rehab & Ext. Care Cumberland Allegany 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 ☐ M 2 💢 F 219-34-6282 71 01/20/1936 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Directo Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 472 Goethe Street 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ 3 ☐ Widowed 4 X Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Baker Geraldine Eleanor 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sheila R. Harper / Daughter 441 Goethe Street, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Mem. Gardens 06/13/2007 LaVale, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Acute Cerebrovascular Accident 3 weeks disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trai Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2XNo 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0023371 June 11, 2007 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7165 Qamar U. Zaman, M.D., 625 Kent Avenue, Cumberland, MD 31. Date filed (Month, Pay, Year) 32 Registrar's Signature State Registrar

		For State	State of Maryland		rtment of He tificate of L			ene g. No. 🗅 📫 🗇	1 2771
		Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
Physic /Med		Florence	Mae		Lower		Month June 7	Day Ye	1745 P M
Exam		4a. Facility Name (If not institution, give st			4b. City, Town, or LaVale	Location of Death		4c. County of E	_{Legany}
Funera Directo		5. Social Security Number 6. Sex	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 07/31/19		Birthplace (State or Foreign Country) aryland
and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Town or Loc	cation				10d. Inside City Limits
Maryla -f sho iled at	ţō	MD Allegar	ny		LaVale				1 ☐ Yes 2 No
with the 3a or 28a	I Director	10e. Street and Number 11206 New York	lvenue, NW		10f. Zip Code	21502	10	g. Citizen of Wha USA	t Country?
Baltimore, IMaryland 21213-5-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2\notin No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
Z I Z I 3-UU30 d within 72 hours af giene. er than "natural", or , the Medical Examl	Completed t	15. Decedent's Educ (Specify only highest grade	ation	(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	uring most of work		6b. Kind of Busin	
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should by Me mark mark	2	Hayes 19a. Informant's Name/Relationship (Тур			ng Address (Street a				
and 2		Carolyn M. Lipscom	b / Daughter		14 New Yor				
Dallamore, Dermit. Pages 1 a Department of Her mportant: If item any injury or othe		20a. Method of Disposition 1 X Burial 2 □Cremation 3 □R: 4 □Donation 5 □ Other (Specify)	cen	netery, cier set Me	sition (Name of matory or other plac emorial P	e) ark 06/11	1/2007	Cumberla	and, MD
permit. Departn Importa any Inju	Š	21. Signature of Funeral Service License	egn Marie		2. Name and Addres				ral Home, P.A D 21502
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bb/bu, fifficate be executed by g physician and sas the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque						
The Cords, F.O. Box of The law requires that the death certificate has been signed by the attending pt age 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome pf pregnand 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea	death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	
w requires that is been signed by should be deta	þ	Part II. Other significant conditions con	ntributing to death but not result		nderlying cause giv	en in Part I.	23e. Did tot		ute to the cause of death?
The law requires to cate has been signed, page 2 should be considered.	Completed	CURONMY M	TENT DISCUSSIONS	-			24a. Was a autops perfori	sy prid med? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
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Or VICEI Physician: Tribis certificate ral director, pa	은	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatie		4 LI Nursing II		ence 6 Other	
Afte fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No			
INISION I or Attending after death. Director: Afte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At hom building, etc. (Specify)	ne, farm, st	reet, factory, office		28f. Location (Si City or Town	treet and Number n, State)	or Rural Route Number,
UNISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of my know ner: On the basis of examination and manner stated.	rledge, dea on and/or ii	th occurred at the tinvestigation, in my	me, date and place opinion, death occu	e, and due to the corred at the time, c	ause(s) and manr date and place, an	ner as stated. d due to the cause(s)
Fo the within Fo the comple	Me	29b. Signature and title of Pertifier			29c. Licens		2		'Month, Day, Year)
2	1) Celler	mo		D3	3417		June 8,	2007
nds		30. Name and address of person who call James R. Moe	ompleted cause of death (item : n, M.D., 1068	^{23a) (Type} Nati	, Print) onal High	way, LaV	ale, Mar	yland 2	1502
	State strar	31. Date filed (Month, Day, Year)	32. Pegistrar's Signatu	ure	barle		-		

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of Maryland / Department of Health and Mental Hygiene	21101

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	/Medic			Ann Mulligan				0 0		2007	3:50 P ^M
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	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
	h with	al D	411 Hamlet Club	Drive		2103	37			USA	
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	S. 13.		dispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	1	14. Race - Ameri Black, White,	
020	urs after al', or Its	by Fu	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No		7 (104)		Specify: wh:	
5	72 ho	Completed	15. Decedent's Education (Specify only highest gra	ducation	16a. Dece	dent's Usual Occup	pation	kina	16b. Kir	nd of Business/In	dustry
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2	hould d Mer narks natic	2	James Bedford 19a. Informant's Name/Relationship (Maupin	10h Mailie	Address (Ctront	Winifi			Combs	Code)
, Ma	and 2 sl salth and n 27 is r		Michael L. Mulli	gan, spouse	411 H	amlet Cl	ub Drive,	. Edgewa	ter,	MD 210	37
allinore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Deportment of Health and Mental Hygiene. Sny Injury or other traumatic svant, the Madical Examiner must be notified at Once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	emetery, crer	sition (Name of matory or other pla tan Cren	atory 06-	Date -04-07		cation - City or To candria,	
	permit. I Depertm Importal any Inju		21. Signature of Funeral Service Licer		22	. Name and Addre	ess of Facility Ra	ausch Fu	nera	1 Home,	P.A.
	102 W G		23a. Part1. Enter the disease, or com	inlications that caused the death			Harmony]			, MD 20	/36 Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	. 50 1101 011	or the mode or dyn	1		1031,		Interval Between Onset and Death
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0	ifficate g phy as the	Medical		U							
DOX	law requires that the death cert as been signed by the ettendin 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 18 months? 1 □ Yes 2 XNo	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnanc Other (specify)	у		2	3d. Date of deliv Month	ery Day Year
	d by t	Phy	9 Unknown		etaine in about		i- Ped I	220 Did to	haaaa	a a contributa to t	he cause of death?
cords,	uires ti signe id be c	d by	Part II. Other significant conditions of	Cancer	nung m me u	nderlying cause giv	ven in Fan I.	1 U Y		Se continbute to t	
3	w req beer shou	Completed						24a. Was	an	24b Were auto	opsy findings available
ב	The law ste has l pege 2 s	E C						autop	med2	prior to co death?	mpletion of cause of
	an: T tificet tor, pe	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes	STANO	1 Tes	2□ No
5	ysicii is cer direct	0	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier	t 3 DOA Ott	200	ome 5 ☐ Resid		Other (Speci	gove Huse
5	Attending Physician: r death. sctor: After this certific by the funeral director,	T :u	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	28c. Inju		28d. Describe h		occurred	
NSION .	endir Bath. or: Al	atic	2 Accident investigation	n			Yes 2□No				
	al or Att	ertification;	3 Suicide 6 Could not b 4 Homicide determined		me, farm, str	eet, factory, office		28f. Location (S City or Tow			al Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Diractor: After this certificate ha completely filled in by the funeral director, page	edical C	29a. Certifier (Check only one) Certifying Ph	nysician: To the best of my knowniner: On the basis of examinat and manner stated.	wledge, deat tion and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	, and due to the orred at the time, or	cause(s) date and	and manner as s place, and due t	stated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	ms		29c. Licens			29d. Date	e signed (Month,	Day, Year)
			Ja We				S283	0	20	s sk	2007
	10		30. Name and address of person who	Jenner, MI	2.90	10 Bost	tacke 8	Pag J#	300	Amas	10h12
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra s Signal	ture	Angell .	2				
DIV	# 17 Day 1/0	001	0011		d Ju	March					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** WILLIAM MURPH 09 06 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL ADVENTIST WASHINGTON MONTGOMERY TAKOMA PARK 5. Social Securify Number 7. Age (In yrs. last birthday Under 24 Hrs. 8. Date of Birth lours Min. (Month, Day, Birthplace (State or Foreign Country) Funeral Hours Months Days 1 ☑ M 2 🗆 F 95 May 12 1912 Bishopville SC 578-14-7391 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 Yes 2 No Director D.C. Washington 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 1110 "I" Street. NE United STates 20002 Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 ∏Yes 2 [∑] If Yes, Give Year or Dates: 2 **X**No 1 □ Never Married 21X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Black Be Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pastor D.C. Government 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charlotte Roberson James Murphy ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Hattie R. Beasley/Daughter 1914 Shadyside Avenue, Suitland, MD 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National Pk. June 15,2007 Laurel, Maryland 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signatur of Funeral Service Lio 5538 Marlboro Pike, Forestville, Maryland 20747 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ronal Failur /Medical Due to (or as a consequence of): **Examiner** Lannh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner I or Attending Physician: The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tyes 2 No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To in by the funeral 27. Manner of Death 1 Natura! 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

SARYA SACUM ate 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Men, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0063703

Those CARROLL

TAKONER BARK, MO

06/10/07

				artment of Health and Mental rtificate of Death	Hygiene Reg. No. 2 0 1)	7 20613
	Physici /Medio		Decedent's Name (First, Middle, Last) FERN ALLEDA	MURRAY 2. Date Montt 06	of Death	3. Time of Death 1506 M
	Examir	ner	4a. Facility Name (If not institution, give street and number) WMHS-BRADDOCK CAMPUS 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death CUMBERLAND If Under 1 Year If Under 24 Hrs. 8, Date (4c. County of Dea	Y
	Funeral Director		5. Social Security Number 215-44-9012 6. Sex 1 M 2 F 61 Yrs. last birthday) Usual Residence of Decedent 7. Age (In yrs. last birthday)	Months Days Hours Min. Marc.	n 12 1946 Wes	rthplace (State or Foreign Country) St Virginia
	e Maryland la-f show tified at	ctor	10a. State 10b. County 10c. City, Town or Low W. Mineral Piedmon			10d. Inside City Limits 1 ☑Yes 2 ☐ No
	ath with the 23a or 28	ral Director	10e. Street and Number 61 Paxton St.	10f. Zip Code 267 50	10g. Citizen of What C United Sta	*
7036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medkal Examiner must be notitied at	d by Funeral	1 Never Married 2 Married 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 ☐ Yes 2 ☒ No Specify:		
21215-0036	be filed within 72 hours after death with the Marylar tital Hygiene. Id other than "natural", or liems 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired) sing Assistant	Nursing Ho	•
yland	2 should be file and Mental Hy is marked oth aumatic event	To Be	17. Father's Name (<i>First, Middle, Last</i>) James Green		Martin	
e, Mar	ges 1 and 2 should it of Health and Men if item 27 is marke or other traumatic		James Murray/husband 61 Pa	ng Address (Street and Number or Rural Route Nexton St., Piedmont, We	est Virginia	26750
baltimor	Pa ant: ury		TEBONIANON OF CHICK (Openiny)	nd Crematory 06/19/ 2007	20c. Location - City of Cumberland	
ם ח	Departition of the control of the co			2. Name and Address of Facility Boal Fi 111 Church St., Western	nport, Marylan	
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	INTERSITIAL LUN	_	Approximate Interval Between Onset and Death UN KNOWN
,00/00	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dical	Due to (or as a consequence of): d. IF FEMALE:			
.O. DOX	w requires that the death certific been signed by the attending p should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 16 months?	Ectopic pregnancy Other (specify)	23d. Date of de Month	elivery Day Year
colds, r	requires that sen signed fould be de	ρ	Part II. Other significant conditions contributing to death but not resulting in the u		Did tobacco use contribute t	to the cause of death? Probably 4 □Unknown
ב ב	sician: The law certificate has by rector, page 2 sh	Completed	25. Was case referred to medical	1_ Y	autopsy prior to performed? death? 'es 2 No 1 ☐ Yes	
5	Physicia r this cert aral direct	: To Be	examiner? 1 Yes 2	- I Training Hollie OLI	nily one) Residence 6 □Other (Speribe how injury occurred	ecify)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1 Natural 5 Pending investigation 3 Suicide 4 Homicide	M 1 Yes 2 No eet, factory, office 28f. Locati	on (Street and Number or R r Town, State)	lural Route Number,
	Hospital 24 hours a Funeral etely filled	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the basis of examination and/or in and magner stated.	n occurred at the time, date and place, and due to vestigation, in my opinion, death occurred at the t	the cause(s) and manner a ime, date and place, and du	s stated. le to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier (Ulu Ulaum Caum M)	29c. License number	29d. Date signed (Mon.	th, Day, Year) 8, 2007
	V		30. Name and address of person who completed cause of death (Item 23a) (Type, William Lamp M) 90	O Seton Dr. Co	mberkin	
į	Sta Registra		31. Date filed (Month, Day, Year) JUN 2 0 2007 32. degistrar's Signature	e Salki		J

			For State Registrar		State o	f Marylar		artmen rtificat				ental Hy	giene Reg. No.	7111	7 2	0611
П	Physici	an	1. Decedent's Name									2. Date of De Month	ath Day	/ Yee		of Death
	/Medi		WILLIA		TCHER N		SON, C					June		2007	9:3	5a
	Examir	ner	4a. Facility Name (If							Location of			4c.	County of De	eath	
			Chester				1	If Under		towr		0.0(8)		Kent		-
	Funeral Director		5. Social Security Nu 213-28-	7972	Sex 1⊠M 2□F	7. Age (In yrs.		Months		Hours	Min.	8. Date of Bir (Month, Da Apr 2	ay. Year)		Birthplace (Sta Country) aryla:	200
	land		10a. State	10b. County		10c. Ci	ty, Town or Lo	cation					-		10d. Inside	City Limits
	72 hours after deeth with the Maryland naturel', or teme 23a or 28a-f show diral Examiner must be putified at	ō	FL	Breva	rd	Pa	alm Ba	v							1 🔯 ነ	es 2□No
	28a	Je C	10e. Street and Num	ber				10f. Zip	Code				10g. Citi	zen of What	Country?	
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	deeth	Funeral Director	11. Marital Status			edent Ever in U	I.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	o-		merican Indian	,
9	after or its	3	1 🗌 Never Marrie	d 2🔀 Marrie	Armed Ford 1 X Yes If Yes, Gr	2 No 1 C	955					Hican, etc.)		Black, W		
933	ours	d by	3 ☐Widowed 4	Divorced	Year or D		58	1 🗆 Yes	ZLALNO	эрөспу:				Specify:	White	
21215-0036	72 h 'natu	Completed		15. Decedent's fy only highest	Education grade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	al Occupa	ation furing mos	t of worki	ng	16b. Ki	nd of Busine	ss/Industry	
121	within ene. then "	m	Elementary/Secon	dary (0-12)	College (1-4or 5+)		<i>DO NOT</i> us Vice					Po	tail	Sales	
	iled v lygie her t		12 17. Father's Name (F		net)		561	A T C C	α .5			(First, Middle			bares	
Maryland	Mental H Mental H arked of	To Be	William	Fleto	her Nic	ckerso	n, Sr	•				ce He			son	
-	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or iteme 23a or 28a-1 show any injury or other traumatic event, the Mudical Examiner must be multiled at ance.		19a. Informant's Nar Rebecca			u (wif						I Route Numb				
ore	of He of He fiten		20a. Method of Dispo		Removal from		Place of Dispo cemetery, crea	sition (Name	ne of ther place	9)	D	ate	20c. Lc	cation - City	or Town, State	•
Ĕ	Pag nent ant: I		4 □ Donation		-	Ke	ent Cr	emat	ion		6/12	2/07	Sm	yrna,	DE.	
Baltimore,	Deperticularity Depertuit.		21. Signature of Pun	eral Service L	Censee	M005	510 G	llena 8 We	d Addres Fu	s of Facilit nera Cros	l Ho	ome of	Stena	ephen	L S 21635	haech
			23a. Part1. Enter the shock or heert	e disease, or c	omplications that only one cause on e	aused the dea									Approxi	
	Physician		Immediate Cause (F	inal		lives	Paile	10	wit	1	1	tasis			Onset a	nd Death
	/Medical		resulting in death)	4	Due to	(or as a consec	mence of):	4		, ,,	00)	1000				
	Examiner		Sequentially list con-	ditions	b	metas)	tatic	Coto.	1	A						
	D #	Examiner	Sequentially list con- if any, leading to immoduse. Enter Underl Cause. Clisease or in	nediate lying	Due to	(or as a consec	quence of):									
	icate be executed physicien and s the burial-transit	cam	that initiated events resulting in death) La		c	·										
60,	cien surrial	Ē	, committee of the comm		Due to	(or as a consec	(uence or):									
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9 ×	death certifical attending pt	Physician/Med	IF FEMALE:		23c Huge ou	tcome of pregn	2004									
Вох	atten for us	ian	23b. Was decedent in the past 12 n	nonths?	1 Live I	oirth 2 ☐ Feta nant at time of c	aldeath 3[Ectopic pr						23d. Date of a Month	delivery Day	Year
P.O.	he de	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown	lNo	9□ Unkn		10a(II) 5 L	Other (sp	өспу)							
	that t ed by detac	문	Part II. Other signific	cant condition	s contributing to d	eath but not res	sulting in the u	nderlying c	ause give	n in Part I.		23e. Did	tobacco u	se contribute	to the cause	of death?
Records,	The law requires that the death certificate be executed as been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Completed by											Yes 2		Probably 4	
ec	law r	pie										24a. Was		24b. Were	autopsy findir	gs available of cause of
<u>~</u>	The ete h page	Sol										perfe	ormed? 2 No	death 1 ☐ Y	?	
Vital	ician: Th certificete rector, pag	Be	25. Was case referre examiner?	ed to medical							of Death	(Check only	one)			
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Sic	Attending ir death. ector: After by the fune	cat	2 ☐ Accident 3 ☐ Suicide	investiga 6 Could no	t bo			М		res 2□						
Division	or Al	Certification:	4 Homicide	determin	ed 28e. Place build	of Injury - At h ing, etc. <i>(Speci</i>	ome, farm, str fy)	eet, factory	r, office		1	28f. Location (City or To			Rural Route N	iumber,
	pital ours e		20a Cantina	A 0 - 11 - 1	Bharleton Tark											
	To the Hospital or Attending Physician: The within 24 hours effer death. To the Funeral Director: After this certificete hy completely filled in by the funeral director, page	Medical	29a. Certifier (Check only 2 one)	2 Medical E	Physician: To the caminer: On the b and man	asis of examination of states.	ation and/or in	vestigation,	at the tim , in my op	e, date an pinion, dea	d place, a th occurre	and due to the ed at the time,	date and	and manner place, and d	as stated. lue to the caus	e(s)
	To the within 2 To the comple	Σ	29b. Signature and t	ne of certifier	1 101	11		290	. License	number			29d. Dat	e signed (Mo	onth, Day, Yea	r)
			▶ //e	not C	T alla	SIL	•		1400	0624	23		6	111/0	+	
			30. Name and address													
_/.	54/VA				laRosa,					Hil.	l Ro	. Che	ster	town	, MD.	21620
	Sta		31. Date filed (Month	Day Year)	2007 32.	gistrar's Signa	ature	best.	,							
	Regist	ar		OH I A	2007	CALLARY.	19									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- State Critificate of Death Certificate of Death		Reg. No.	200	7 2051
Physic /Med		1. Decedent's Name (First, Middle, Last) William Page Neville	2. Date of De Month June 8	Day	Year 7	3. Time of Death 7:40 PM
Exam		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of December 1	ath		unty of Death	
Funera Directo		5. Social Security Number 213-22-6216 6. Sex 1 M 2 F 78 7. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 9. A		th.	9. Birtl	pplace (State or Foreign untry) PA
ne Maryland 8a-f show	Director	Usual Residence of Decedent		10a Citizon	n of What Co	10d. Inside City Limits 1 □ Yes 2√√No
3a or 2		Snug Harbor Rd. P.O. Box 2 21811		USA	TOT WITH CO	and y:
Baltimore, Maryland 21213-5-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 ☑ Yes 2 □ No If Yes, specify Cuban, Mexican, Pu 1 ☑ Yes 2 ☑ No If Yes, Specify Cuban, Mexican, Pu 1 ☑ Yes 2 ☑ No Specify:	(Specify Yes or No erto Rican, etc.)		Black, White	
Z1Z15-UU36 ed within 72 hours aff giene. er than "natural", or t, the Medical Examil	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of v life. DO NOT use retired)	vorking	İ	of Business/	•
C Z I	e Con	12 Forest Ranger 17. Father's Name (First, Middle, Last) 18. Mother's N	lame (First, Middle			<u>igriculture</u>
Maryland the 2 should be file the and Mental Hy 77 Is marked other traumatic event	To Be	William George Neville Violes		O't7	04-4- *	En Codel
Mar nd 2 sho lth and 27 Is m		19a. Informant's Name/Relationship (Type. Print) Barry Neville / son P.O. Box 913, Berli			own, State, 2	(ip Code)
Baltimore, Mc permit. Pages 1 and 2. Department of Health a important: If item 27 is		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) St. Paul's Churchvard 6	Date	20c. Loca	tion - City or	
baltir permit. P Departme Importan any Injur	N N	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 108 William St.,	The Burba	age Fu	neral	Home
68760, tificate be executed B was and as the burial-transit	Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or highly that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			3/1	VELAL Y E
death cer attendir d for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23	d. Date of de Month	ivery Day Year
w requires that the cheen signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use		the cause of death?
Hec law has by ye 2 s	Completed		24a. Wa auto per 1□ Yes	opsy formed?	24b. Were at prior to death?	utopsy findings available completion of cause of 2 No
Or VITAL P Physician: Th this certificate ral director, pag	Be	examiner?	Death <i>(Check only</i>		Other (See	soifu)
Jing Jing Afte fune	ition: To	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 1 Accident investigation 28c. Injury at Work? M 1 Yes 2 No	28d. Describe			(City)
i diffe	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or To	(Street and own, State)	Number or R	ural Route Number,
e Hospital 124 hours a Re Funeral	Medical (29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and p Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of and manner stated.	lace, and due to the	e cause(s) a e, date and p	ind manner a place, and du	s stated. e to the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License number				th, Day, Year)
		Josephy C. Hospital M. J. 306241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. P. OTTY, C. HOLZWORTH, M. D. 303 SM		06	-10-	- 87
BAIDTI	State	31. Date filed (Month, Day, Year) 32 Registrar's Signature 32 Registrar's Signature	Day St.	SHOW	HILL,	MD, 2186
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JUNE 20, 2007 IRENE ANDERSON OLDS 8:15p М /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CHAS.CO.NUR.& REHAB.CENTER LA PLATA CHARLES 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Birthplace (State or Foreign Country) Days Months 1 M &F Hours Min. Director 89 414-22-9885 7-9-1917 TENN. Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location show 10d. Inside City Limits is 23a or 28a-f shov Director MD. CHARLES 1X Yes 2 No LA PLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10200 LA PLATA ROAD 20646 U.S.A. Pages 1 and 2 should be flied within 72 hours after death ment of Health and Mental Hygiene.
snt: If item 27 Is marked other then "naturel", or items 23. Lry or othar traumalic event, the Nedical Examinar must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 Yes 2 No Specify Specify: WHITE 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th SHOEMAKER FACTORY WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOSEPH LEROY ANDERSON VERA OUTLAW WHITE 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRENDA RUSSELL-DAUGHTER 4010 BREWSTER LN. WALDORF, MD. 20601 20b. Place of Disposition (Name of cemetery, crematory or other place)
NEBO CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 6-30-07 4 □ Donation 5 □ Other (Specify) CRUCIFER, TN. 21. Signature of Funeral Service Licensee MOO479 22. Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. Use LA PLATA, MD. 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyings such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) est brovasi Physician distah /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ox 68760, & attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 2 Fetal death 3 DEctopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year signed by the a d be detached to 5 Other (specify) P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ been si should I 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 🗆 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, pagn Division of Vital 2 No 1 Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1□Yes 2□No Other: P 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Natural 5 Pending 2 Accident investigation М 1 TYes 2 TNo 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 120 SAL 200 0/14 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 2007 June 1402 РМ Ethel Virginia Petty /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Ceci1 297 Hollingsworth Manor E1kton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Hours Days 1 □ M 2 🛣 F Yrs 215-32-3803 June 25, 1926 Director 80 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b, County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the M-dical Examiner must be notified at 1 Y Yes 2 □ No Director Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 297 Hollingsworth Manor 21921 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify Specify: þ White 3 🕅 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) In Her Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event once. Be William Walters Ethel Milburn 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patsy L. Weaver/Daughter 264 Mount Olivet Rd., Oxford, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State Chesapeake City, 20a. Method of Disposition June 22. 1 Burial 2 □ Cremation 3 □ Removal from State Bethel Cemetery 4 □ Donation 5 □ Other (Specify) 12007 Maryland 21. Signature of Funeral Service Licensee Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): yh /Medical Examiner Metastatic Vaginal Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Adenocarcyona y Uterus and Vageno sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2ڱNo Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2: autopsy performed? 1 Yes 2 No certificate the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Private Physician 6 20 200 026327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cydney T. Teal M.D. III west than St. Ste 312 Ellyon

State Registrar DHMH 17 Rev 1/2001 31. Date filed (Month, Day, Year)

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32 Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Colton Meyer Pryke 2007 3:31 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Hagerstown Washington f Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 X M 2 □ I Yrs June 11, 2007 Pennsylvania N/A Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 Tyes 2 XNo Director Pennsylvania Franklin Greencastle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17225 3589 Brook Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: White Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert A. Pryke Erin Meyer Pryke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce. Robert A. Pryke/Father 3589 Brook Street, Greencastle, PA 17225 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 6/15/2007 | Hagerstown, Maryland Rest Haven Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service License Rest Haven Funeral Chapel 1601 Pennsylvania Avenue, Hagerstown, Md. that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) **Physician** Treme /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence of): Examine requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the use as IF FEMALE: Home 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 07 6 signed by tl d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 Tyes 2 No 3 Probably 4 Unknown has been signed 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page performe certificate 1□ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 PER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient 2 After this 28b. Time of Injury 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Certification: To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) nd manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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DHMH 17 Rev 1/2001

State

JUN 1 5 2007 Registrar

31. Date filed (Month, Day,

Antie tam strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hagerstown Maryland

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2007 6:55 AM^M June 13, Mahlon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Charles 1022 Dartmouth Road Waldorf If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 03-03-1922 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Hours Months 1**X** M 2□ F Yrs 213-14-6393 85 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County ir than "natural", or Itams 23a or 28a-f show The Modical Examinar must be notified at 1 XYes 2 □ No Director Waldorf Charles 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20602 USA 1022 Dartmouth Road Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates: δ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade com grade completed) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygient Important: If item 27 is merkad othar tha any injury or othar traumatic evant. Ite.) once. Agriculture Farmer none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mahlon Price Orpah Shores 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1022 Dartmouth Road, Waldorf, MD 20602 <u>Joe Ann Price/daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/15/2007 Beechwood Cemetery Princess Anne, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Fignature J Functal pervige Licensee. 22. Name and Address of Facility Hinman Funeral Home 11673 Somerset Ave., Princess Anne, MD 21853 .M00295 Approximate Interval Between Onset and Death a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ammediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed signed by the attending physician and doe detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No lumona 1 ☐ Yes 2 ☐ No or Attending Physician: 26. Place of Death Check onl one Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Certification; To ieral Director: After this 28d. Discri e how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D22574 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Leatherwood, M.D. 12070 Old Line Center, Suite 302, Waldorf, MD 20604 12 EB 31. Date filed (Month, Day, Year) State JUN 1 5 2007 Registrar

3. Time of Death

Baltimore, Maryland 21215-0036

Demit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.

Important: If them 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at pronce.

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

10:40 P Dorchester 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Jan • 15, 1963 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 1 □ M 2 🔀 F Days 217-86-2323 44 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Cambridge MD Dorchester 1X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21613 701 Race Street, Apt. 104 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luvell Lane John Hubbard, Sr. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 162, Secretary, mD 21664 Luvell Hubbard Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removal from State 6/8/2007 Salisbury MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street, Cambridge, MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Peritonitis 2 weeks Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or i.ijury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 🏋 No 3 Ectopic pregnancy Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1

Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) 1 X Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43238 June 7, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Bramble St. Cambridge, MD 21613 William Bair 31. Date filed (Month, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

JUN 1 1 2007

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			1 For State	State of Maryland			Mental Hygi	ene	20623
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9	leath certificate attending phys d for use as the	ician/Medi	IF FEMALE:						
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Division of Vital Records,	Attending Physician: r death. ector: After this certifics by the funeral director, i	O B	examiner? 1 ☐ Yes 2 🖫 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3□	1.04		nce 6 Other (Spe	cifv)
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			30. Name and address of person who d	completed cause of death (Item	23a) (Type, Print)		V-2000000000000000000000000000000000000	n new market	
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Mary	2 should be and Mentai is marked raumatic ev		19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street	and Number or Ri	ural Route N	umber, Cit	y or Town, S	tate, Zip	Code)
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g R	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.		21. Signature of Funeral Service Lice	P. Cre			325 Mt. I				ral Ho s, MD		•
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death	. Do not ent	er the mode of dyi	ng, such as cardia	c or respirato	ory arrest,	•		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Doment	ia el	he to	Alzhen	in Disco.	Jŧ				Onset and Death
<u>}</u>	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):							
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X R R	death certi e attending id for use a	Physician/M	in the past 12 months?	1□Live birth 4□Pregnant at			Ectopic pregnanc Other <i>(specify)</i>	у		_	Mont		Day Year
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			1 David	Todo n	N		04	76/0		5	une	7	2007
	0		30. Name and address of person who						-				
	X		David J. Tardio, 31. Date filed (Month, Day, Year)						ns, MD	2068	38		
î	Sta Registr		JUN	5 2007 ▶	a digital	1 15	Sparke	2					

			For State Registrar#26 per						rtment of			-	jiene	2007	20	625	
A	mend it	em	Negistrar # 2.0 per Decedent's Name (First, Middle		iciiu/ c)-2.1)// U.I.	3001	imouto or	Dodin	1	2. Date of Dea			3. Time	of Death	
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4	/Medic Examin		Jane 4a. Facility Name (If not institution	n, aive str	eet and nui	_Mari∈ mber)	<u> </u>		Ruckma 4b. City, Town,		of Death	0	14	4c. County of Death			
	Examili	EI	10518 Cathell	-					Berlin				,	Worcest	er		
	Funeral		5. Social Security Number	6. Sex		7. Age (In	yrs. last b	irthday)	If Under 1 Year		24 Hrs. Min.	8. Date of Birth (Month, Day)	9. Birt	hplace (State	or Foreign	
	Director		219-38-8239	1 🗆 N	VI 2.2 F	6	55	Yrs.	Months Days	Hours		July 5,					
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	aryia shov	-	10a. State 10b. County			100	c. City, Tov	WII OF LOC	canon							s 2 No	
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Maryland	12 sh n and r Is m		19a. Informant's Name/Relations		-				g Address (Stree						zip Gode)		
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87	physicate the	Physician/Medical		d.													
9 X	eath certific attending pl	/Me	IF FEMALE:	230	c. If yes, ou	tcome of p	regnancy						2	3d. Date of de	livery		
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ita	ysician: The is certificete he director, page	Bec	25. Was case referred to medical examiner?	al 📗		,				26. Place	e of Death	Check only o	ne)				
× ×	Physician; this certific ral director.	ျှ	1 ☐ Yes No	Ho	spital.	npatient		_	J JUDON			ne 5 🔀 Resid			icify)		
Ĕ	ding P. After t	e E	27. Manner of Teath Natural 5 Pendi		28a. Date (Mon	of Injury oth, Day Ye	ar) 28b.	. Time of Injury	W		1	28d. Describe h	now injury	occurred			
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	spitai		29a. Certifier Certifyi	ing Physic	cian: To the	e best of m	y knowled	ge, death	occurred at the	time, date ar	nd place,	and due to the	cause(s)	and manner a	s stated.		
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check only 2 Madica one)	I Examina	and man	pasis of exa	amination a	ind/or in	estigation, in my	opinion, dea	ath occurr	ed al the time,	date and	place, and du	to the cause	e(s)	
	vithin 2 To the comple	Σ	29b. Signature and title of certific	er_	, / /		111			nse number				e signed (Mon.)	
	NOD.		CAS (4	JV	VIU		Pa	7627	18		6	-15-	0/		
	100		30. Name and address of person		npleted cau	s f death	(Item 23a) (Type,	Print)	1757	0	()	1.1	71	802		
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			1 - State Registrar	State of Mary			ite of L		vientai n y	gien Reg. N		7 35	7 ~ 7	
	Physici	an	1. Decedent's Name (First, Middle, La	st)					2. Date of De Month		ay Year	3. Time of	Deeth -	
	/Medic	al_	BETTY JANE		REED	1			06	07	2007	0730	M	
	Examin	er	4a. Facility Name (If not institution, given WMHS - MEMORIAL			4b. Cit		Location of Death	1	4	c. County of Death ALLEGAN			
T	Funeral		5. Social Security Number 6. S	Sex 7. Age (Ir	yrs. last birthda		ler 1 Year	If Under 24 Hrs.	8. Date of Bi	irth 9. Birthplace (State or Foreign				
	Director		220-01-0303	□M 2XF 87	Yrs.	Month	s Days	Hours Min.	(Month, Di 07/23/	191 ¹	gar) Country)			
	and w		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or I	_ocation						10d. Inside Ci	ty Limite	
	Maryl f sho ied a	tor	MD Allega				rland	l				1 ∑Yes		
	n the	Director	10e. Street and Number		·	10f. 2	Zip Code			10g. C	itizen of What Cou	ntry?		
	th wit	alD	1010 Harding	Avenue			ä	21502			USA			
	tems	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13	. Was Dec	edent of Hi becify Cuba	spanic Origin? (S in, Mexican, Puert	pecify Yes or No o Rican, etc.)	0-	14. Race - Ameri Black, White,			
36	should be filled within 72 hours after death with the Maryland nd Mental Hyglene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	1 Tyes 2 No If Yes, Give Year or Dates:		1 ☐ Yes	2🛛 No	Specify:			Specify:	hite		
Š	2 hou atura ical E	ted	15. Decedent's Ed	ducation	16a. Dec	edent's Us	sual Occupa	ation		16b. i	Kind of Business/In			
2	ithin 7 ne. nan "r	Completed	(Specify only highest gra	College (1-4or 5+)	life.	DO NOT	use retired		king					
72	lled w dygiel ther th		12 17. Father's Name (<i>First, Middle, Last,</i>	2		Home	emakei	18. Mother's Nan	on /First 8 sidely		Home			
auc	d be f ental I ked of	To Be	Roscoe	т.	McElfi	sh		Marie		, maide Col	surname) Senki	heil		
Maryland 21215-0036	shoul and M s mari	ř	19a. Informant's Name/Relationship (Type. Print)			ss (Street a	and Number or Ru			or Town, State, Zij			
	and 2 salth a n 27 is		Nancy J. Berry /	Daughter				venue, Ci						
ore	ges 1 t of He if iten or oth		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □		20b. Place of Disp cemetery, cr	osition (N ematory o	ame of r other plac	e)	Date	20c. l	ocation - City or T	own, State		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 6 ☐ Other (Specif	(v)				dens 06/			Vale, MD			
Ba	Depai Impor any Ir		21. Signature of Funeral Service Licer	/ reland				ar Street			Funeral	Home, 21502	P.A.	
	*		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the								Approximate Interval Bet	9	
	Physician		Immediate Cause (Final disease or condition	SEP	515							Onset and I	Peath	
	/Medical Examiner		resulting in death)	Due to (or as a co	nsequence of):							1.011	-	
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Ö,	e exerian ar		resulting in death) Last	Due to (or as a co	nsequence of):									
68760,	rtificate be executed og physician and as the burial-transit	Aedical		d	<u></u>									
Box (n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf p						,	23d. Date of deliv	en/		
<u> </u>	that the death cer	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		☐Ectopic ☐Other (pregnancy specify)				Month	-	/ear	
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<u> </u>	Physician: this certific al director,	2	1 ☐ Yes 2 ☑ No	Hospital: Impatient	2 ER/Outpation	ent 3 🗆 [4 □ Nursing H	ome 5□Res	idence	6 ☐Other (Speci	fy)		
Division or Vital	Jing I	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	ear) 28b. Time Injury		28c. Injury Work		28d. Describe	how inju	ry occurred			
/ISIC	or Attencatter death Director: in by the	ficat	2 Accident investigation 3 Suicide 6 Could not be 4 Demicide determined	28e. Place of injury -	At home, farm, s	M treet, facto		Yes 2 □ No	28f. Location (Street a	nd Number or Run	al Route Num	her	
ó	s after al Dire	Certification:	4 ☐ Homicide determined	building, etc. (S	Specify)				City or To	wп, Sta	te)	2. 110010 170111	2011	
	Hospital 24 hours : Funeral tely filled	Medical	29a. Certifier (Check only one) 1 ★ Certifying Ph	ysician: To the best of m	amination and/or	ath occurre	ed at the timon, in my op	ne, date and place pinion, death occu	, and due to the	cause(s) and manner as s	stated. to the cause(s)	
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	Mec	29b. Signature and title of certifier	and manner stated			9c. License				ate signed (Month,			
	5		• 2	enderf.			06	033280			ne 7, 200			
			30. Name and address of person who	completed cause of death	(Item 23a) (Type	Print)		1.	12: 1	- 4	ERLAND I	m		
	n ded Sta	to.	SUNIL OUPTA 1 31. Date filed (Month, Day, Year)	32. Registrar's	KENT	HVE	NUE	SUITE	101, U	MB	FRLAND ,	1111/2	1502	
	Registr			007	1 15	boots								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 5, 2007 11:47 A.^M JUNE SARAH MARIE KELLEY RORICK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY CUMBERLAND NURSING HOME CUMBERLAND If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Social Security Number Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 XF 3, 91 Oct. 1915 Director 214-28-7002 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County rai", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 □ No Director MD Cumberland Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or ury or other traumatic event, the Medikal Examiner must be I 29 N. Lee Street 21502 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: by 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Insurance 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank C. Trozzo Mary Perelli 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Franklin Street, Cumberland, MD Mary Lou Dawson / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SS. Peter & Paul Cem. 06/09/2007 Cumberland, MD 22. Name and Address of Facility Upchurch Funeral Home, P.A. 21. Signature of Funeral Service Licens 21502 202 Greene Street, Cumberland, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10 minutes disease or condition resulting in death) /Medicai Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 ☐ Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) be detached the 9 Unknow signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 1 🗌 Yes 2 No 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 221No 2 No 1 ☐ Yes 1☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗀 Yes 1 Inpatient 3□ DOA 2 ☐ ER/Outpatient ပ this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury Certification: (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

or Attending Physician: To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

NAS

31. Date filed (Mo State Registrar

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Medical

(Example 1) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

death (Item 23a) (Type, Print)

6000 Carru

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 06 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7407 Upshur Street Prince George's Landover Hills 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**√**M 2□F , Year) 26 Months Feb 19, 578-24-6700 81 Mary Tand Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Items 23a or 28a-1 shov ury or other traumatic event, the Medical Examiner must be notified at Maryland Prince George's 1XYes 2 No Director Landover Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7407 Upshur Street 20784 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No WWII If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 Specify. White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Tractor Trailer Driver Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter L. Rush Olive Duley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marquerite M. Rush (Wife) 7407 Upshur Street, Landover Hills, MD 20784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Chesapeake Crematory 6/12/2007 4 ☐ Donation 5 Other (Specify) Beltsville, MD 21. Signatus Funeral Service Licensee 22. Name and Address of Facility Rendon-Hale Funeral Home 9013 Annapolis Road, Lanham, MD 20706 Part1. Enter the disease, shock, or heart failure. L or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, istemy one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nutas Physician minte resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). that the death certificate be executed Exami and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physiciar Physician/Medical as the use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9☐Unknown 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s autopsy perform certificate 2 1 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of ne Hospital or Attending P n 24 hours after death. ne Funeral Director; After t 28d. Describe how injury occurred After Certification: 28c. Injury at Work? Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Chief Medical Officer 2007 D 21438 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. LaPenta, M.D.,

CF ()

State Registrar Hospice of the Chesapeake, 445 Defense Highway, Annapolis, MD

31. Date filed (Month, Day, Year)

32. Registrar's Signature.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death | Certificate of Death

Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show
any Injury or other traumatic event, the Medical Examiner must be notified at
once.

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760, E.J. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

cal		DRENTZ	F.		RAWLING	S		06	14		07	1314	М
ner	4a. Facility Name (If not institution, give	street and nun	nber)		4b. City, Town, or	Location of	Death		4c. County of Death				
5	WMHS BRADDOCK	CAMPUS			CUMBER					AL	LEGA		
	5. Social Security Number 6. So	ex M∑M 2□F	7. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min.	8. Date of Bir (Month, Da	ay, Yea		Co	thplace (State or ountry)	
	235-52-5352 Usual Residence of Decedent		74					May 26	, 19	33	LIK	Garden,	WV
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ecto	WV Minera	1	Κe	yser					1 ☐ Yes 2 X No				
ä	10e. Street and Number			10f. Zip Code						Citizen of	f What Co	ountry?	
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Ē	11. Marital Status 1 □ Never Married 2 ☑ Married	Armed For	ces?	IS. W	Vas Decedent of H Yes, specify Cuba	an, Mexican,	Puerto	Rican, etc.))-		ack, White		
b	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv Year or Da	e A.	1	☐ Yes 2X No	Specify:				Spec		Thite	
Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Decede	ent's Usual Occup	ation during most o	of worki	na	16b.	Kind of I	Business/		
mpl	Elementary/Secondary (0-12)	College (1	-4or 5+)		kind of work done of NOT use retired			g	١.	. /5	. 1	.	
ပ္သ	9 17. Father's Name (<i>First, Middle, Last</i>)			Aut	o/truck i			(First, Middle				Repair	
To Be	Leonard Maxwell		S					et Clos		on ourne			
-	19a. Informant's Name/Relationship (7			19b. Mailing	g Address (Street					y or Towi	n, State, 2	Zip Code)	
	Charlotte A. Rawl	ings/ W	ife	Rt.	6, Box 6	528	Kev	ser. W	7	2672	26		
	20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from 9		ce of Dispos netery, crem	sition (Name of natory or other place	e) Jur	ne Î	ate 8	20c.	Location	- City or	Town, State	
	4 □ Donation 5 □ Other (Specify				metery	2	2007		A	ntio	ch, V	VV	
	21. Signature of Euneral Service Licen	5° / -	1	1	Name and Addres		Om.	ith Fur			ome		
	23a. Part1. Enter the disease, or comp	Y+uu	aused the death		5 S. Mai					WV	267	26 Approximate	
	shock, or heart failure. List only	one cause on e	ach line.	Do not ente	if the mode of dyin	ig, such as c	artilac c	i respiratory a	irresi,	ě.		Interval Betwo	een eath
	disease or condition resulting in death)	a. Chn	OMIC or as a conseque	Obst	cuctive	- 1001	Mo	NARY		SEF	1SC	51/a	JRS.
			or as a conseque	ince on).									
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (ui as a cunscyud	rice of.									
ami	Cause (Disease or injury that initiated events resulting in death) Last	c											
Ē	resulting in death) Last	Due to (or as a conseque	nce of):									
hysician/Medical Examiner		.d											
N N	IF FEMALE: 23b. Was decedent pregnant		come pf pregnanc							23d. D	ate of del	livery	
sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		irth 2 □ Fetald ant at time of dea		Ectopic pregnancy Other (specify)					N	M onth	Day Ye	ear
Phys	9 Unknown							T					
	Part II. Other significant conditions of	ontributing to de	ath but not result	ing in the un	deriying cause givi	en in Part I.				o use co 2∐ No		o the cause of de robably 4 □Ur	
Completed by	CELL CLINOMICO	_01_~	"''				_	, , , , , , , , , , , , , , , , , , ,					
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e Cc	25. Was case referred to medical					26 Place o	of Death	1□ Yes	2 💢		1 ☐ Yes	2 □ No	
To Be	examiner? 1 ☐ Yes 2 💢 No	Hospital:	npatient 2 El	R/Outpatient	3□ DOA Oth	er		ne 5⊟Resi		6 □0	ther (Sne	cify)	
Ë	27. Manner of Death 1 X Natural 5 Pending	28a. Date of	of Injury 2 h, Day Year)	28b. Time of Injury	28c. Injur Worl			28d. Describe				<i>,</i>	
catic	2 Accident investigation 3 Suicide 6 Could not be					Yes 2 □ N	0						
ığı.	4 Homicide determined	Zoe. Flace	of injury - At homing, etc. (Specify)	ie, farm, stre	et, factory, office		2	28f. Location (City or To	Street wn, St	and Nun ate)	nber or Ru	ural Route Numb	er,
Ce	29a. Certifier 1 Certifying Ph	vsician: To the	best of my knowl	edge, death	occurred at the tir	ne. date and	nlace	and due to the	Callea	e(s) and r	manner as	stated	
Medical Certification:	(Check only 2 Medical Exam	niner: On the ba and mann	asis of examinatio	on and/or inv	estigation, in my o	pinion, death	h occurr	ed at the time	date	and place	e, and due	e to the cause(s)	
M	29b. Signature and title of certifier				29c. Licens	e number			29d. l	Date sign	ned (Mont	h, Day, Year)	
	pyfun					33581			Ju	me	15,	2007	
	30. Name and address of person who	completed cause	e of death (Item 2	23a) (Type, F	Print)	1		berla		10	17	21603	
ate	31. Date filed (Month, Day, Year)	32. R	egistrar's Signatu	re re	TIVENUE	2 [JIN	DEKIL	NO	$I_{+}II$	W	XIDUA	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Staudenmeier Raymond JUNE 20TH, 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Aug 30, Aug 30, Aug 30) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral ¼** M 2□ F Yrs. 79 Director 187-24-7649 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at Allegany Cumberland MD Funeral Director No Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or dical Examiner must be 10 N. Liberty St. Apt. 608 21502 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nnt: If item 27 Is marked other than "natural", or ite 1 Never Married Married 1 ☐ Yes 2☐No Baltimore, Maryland 21215-0036 Specify: white Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Groves Construction** supervisory engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Caroline Schue Staudenmeier Frank Staudenmeier ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 N. Liberty St. Apt. 608 Cumberland MD 21502 19a. Informant's Name/Relationship (Type. Print) wife Georgia Staudenmeier 20b. Place of Disposition (Name of cemetery, crematory or other place) Scarpelli Funeral Home, P.A. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/21/2007 Department of Important: If any Injury or Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fun ral Service Licensee ^{22. Name} Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi te Cause (Final disease or condition resulting in death) **Physician** CEREBROVASCULAR ACCIDENT 2 DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading of influential cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner aw requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s perforn 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. F. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 21 2007 D33280 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) GUPTA, SUNIL K., M.D., 625 KENT AVENUE, SUITE 101, CUMBERLAND, MD 21502

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUN 2 6 2007

Registrar's Signature

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 0830AM 2001 /Medical 12 4a. Facility Name (If not institution 4c. County of Death 4b. City. Town, or Location of Death Examiner alpo astm If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 223-30-0508 Director 83 DEC. 1923 VIRGINIA 5, Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ?7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No DORCHESTER HURLOCK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6356 SUICIDE BRIDGE ROAD 21643 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by Specify: WHITE 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any Injury or other traumatic event, the Media once. Elementary/Secondary (0-12) College (1-4or 5+) 8 -0-HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be AARON JUSTICE JESSIE HUBBARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILTON J. BRUNNER/ SON 6543 AIRPORT ROAD, LAUREL, DE 19956 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State CHESTERFIELD CEMETERY 4 Donation 5 Dother (Specify) 6-16-2007 CENTREVILLE, MD 21. Signature of eral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** respiration /Medical r as a consequence Examiner eamour Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed 055h burial-tran and Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical the for use as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown the 9□Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No certificate has autopsy performed? 1∐ Yes 2 No Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? or Attending 1 Natural 5 ☐ Pending investigation (Month, Day Year) death. 2 Accident 1 ☐ Yes 2 ☐ No nin 24 hours after death the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. pletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN *

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Douglas Ray SWOPE June 11, 2007 2204 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 16904 Warbler Court Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Months Days Hours Min 1**X** M 2□ F 54 9, 1952 220-58-3520 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 21X No Maryland Washington Hagerstown 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 16904 Warbler Court 21740 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 TrNo white Specify. Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) distribution 10 packer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Jane Reigle Joseph Donald Swope Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Dagenhart - sister 536 Guilford Ave., Hagerstown, Md. 21740 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hagerstown Crematory 6/13/07 Hagerstown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service License MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): dia Vuxular Disease disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Onknown 2□ No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ D0A 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 ⊞Natural 5 ☐ Pending investigation Injury 1 Yes 2 ☐ Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician /Medical Examiner Examine death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

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Department of H Important: If Ite any Injury or ot Pages '

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Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

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Physician/Medical þ Completed Be 2 Certification:

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To the

State Registrar

DHMH 17 Rev 1/2001

Medical

Edward Vitte 31. Date filed (Month, Day, Year) **JUN 13**

29b. Signature and title of certifier

29a. Certifier

(Check only one)

DI

Name and address of person who completed cause of death (Item 23a) (Type, Print)

19,011 Orcha 32. Registrar's Signature

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month. Day. Year.

terme Bd flynstown, MD2174c

		-	For State Registrar	State of Maryland		artment of H rtificate of L		vientai Hy	giene Reg. No.	111177	11100
	8	je.	Decedent's Name (First, Middle, Last)					2. Date of De	ath	Year	3. Time of Death
c.	Physicia /Medic		Nanci Coburn Stari	c				June June			7:00 A M
	Examin		4a. Facility Name (If not institution, give stre				Location of Death	ı		county of Death	
7,	· · · · · · · · · · · · · · · · · · ·		Shady Grove Adventis 5. Social Security Number 6. Sex	st Hospital 7. Age (In yrs. la	est hirthday)	Rockvill If Under 1 Year		8. Date of Bir	rth	ntgomer	-
	Funeral Director			1 2 K) F 61	Vvo	Months Days	Hours Min.	Sept 1	9, ^{Year)}	45 New	place (State or Foreign htry) Jersey
	P		Usual Residence of Decedent		, Town or Lo	ocation				1	0d. Inside City Limits
	larylar show	ğ	10a. State 10b. County								1 □Yes 2X No
	the N 28a-f notifie	Director	MD Montgomery 10e. Street and Number	Mont	gomer	y Village 10f. Zip Code			10g. Citiz	en of What Cour	ntry?
	h with 23a or st be	al Di	19301 Watkins Mill	Rd•		20886			USA		
	r deat	Funeral	11. Marital Otatus	. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	0- 1	 Race - Americ Black, White, 	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show anmatic event, the Medical Examiner must be notified at aumatic event, the Medical Examiner must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐XNo	Specify:			^{Specify:} Whi	te
Maryland 21215-0036	2 hour	ted !	15. Decedent's Educa	tion	16a. Dece	dent's Usual Occup	ation	kina	16b. Kin	d of Business/In	dustry
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2	led wi lygien her th nt, the	Co	17. Father's Name (First, Middle, Last)	2	Dog G	roomer	18. Mother's Nan	ne (First, Middle		oming Surname)	
and	~ = 0 2	Be	George Ross Starr,	Jr.			Barbara	•			
ary.	should be f and Mental I s marked oi umatic eve	P L	19a. Informant's Name/Relationship (Type	. Print)		ng Address (Street					o Code)
ž	and 2 salth a 27 Is er trai		Gary MacDonald Star			eybridge	Rd. Weyb				
Baltimore,	ges 1 of He If Item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer	moved from State	emetery, cre.	osition (Name of matory or other place		Date		cation - City or T	
<u>=</u>	t. Pagrimen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature → Juneral Service Licensee			ke Cremat				sville,	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev once.		21. Signature of uneral service Licessee	1 1 1		2. Name and Addre Oing Home					x /84 e. MD 21029
×			23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	ations that caused the death	Do not en	ter the mode of dyir	ng, such as cardia	c or respiratory	arrest,	II ASVIII	Approximate Interval Between
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100	/Medical Examiner		resulting in death)	Due to (or as a consequ							
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Box	death certif e attending ed for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 🛣 No	1☐Live birth 2☐Feta 4☐Pregnant at time of d		□Ectopic pregnanc □ Other (specify) _	у			Month	Day Year
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or Vital	ys Si	To B	examiner? 1 ☐ Yes 2 No	ospital: 1 XInpatient 2 🗆		III 3 DOA				6 ☐Other (Spec	ify)
o u			27. Manner of Death 1X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time e Injury	Wo	ryat rk?]Yes 2∐No	28d. Describe	e how injur	y occurred	
Division	Attending r death. ector: After by the fune	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At ho			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	28f. Location	(Street an	d Number or Ru	ral Route Number,
<u>S</u>	al or A s after Il Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specif	y)			City or I	own, State)	
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:		(Check only 2 Medical Examin	cian: To the best of my kno	wledge, dea	ath occurred at the t investigation, in my	ime, date and plac opinion, death occ	ce, and due to the curred at the tim	e, date and	and manner as place, and due	stated. to the cause(s)
	the P	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Dat	e signed (Month	n, Day, Year)
	So With	_	Can	Hi.		D4116				10, 200	
	.3		30. Name and address of person who cor	inpleted cause of death (Item	n 23a) (Type		4 -		o une	209 200	
(3)	42		Vinu Ganti, M.D. 19	9529 Doctor's	Drive		own, MD	20874		·	
	St. Regist	ate	31. Date filed (Month, Day, Year)	32. Resistrar's Signa		have.					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 14, 2007 2:15 P. M Virginia Lee Stakem 4a. Facifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 14948 Paradise Street Midland Allegany If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6 Ser 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min 1 ☐ M 20X F Maryland Yrs. November 25, 1927 79 212-24-0735 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 No Midland Maryland Allegany 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21542 U.S.A. 14801 Railroad Street, Apt. B 12, Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ₩Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/fndustry Elementary/Secondary (0-12) Colfege (1-4or 5+) 0 Postal Service Clerk Mail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Carrie Harr **Everett Springer** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14948 Paradise Street, Midland, Maryland, 21542 Rebecca Violante - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 18. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Midland, Maryland St. Joseph's Catholic Cemetery 2007 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 21. Signature of Funeral Service Licensee 8 East Main Street, Lonaconing, Maryland 21539 23a. Parti/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf ntoucrania disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (o. as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Monknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 2 No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred

Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Division of Vital Records, P.O. Box 68760, signed by the e peeu page 2 s To the Hospital or Attending Physician: ector, Director: After this of in by the funeral director death. after within 24 hours a To the Funerel C

Physician

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permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f ehow any Injury or other traumatic event, the Madical Examinational be notified at any once.

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. Peges 1 and 2 should be file tment of Heelth and Mental Hi tant: If Item 27 Is marked oth

Physician

/Medical

Examiner

altimore, Maryland 21215-0036

death with the Maryland

Completed by Physician/Medical To Be Certification: 29a. Certifier Medical

1 Yes 27. Manner of Death 1 Natural 2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

29c. License number

Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

homa 31. Date fifed (Month, Day, Year) 32. Registrar's Signature

JUN 18 2007



State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year Evelyn M. Shepley 2007 7:55 A /Medical June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16911 Pickwick Lane Washington Hagerstown 8. Date of Birth Aug 25, 1922 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1□ M 2 F Months Days Min. 84 214-16-8204 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ıral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Washington Hagerstown 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code 21740 USA Funeral J 16911 Pickwick Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify. Specify: White þ 3 XWidowed 4 ☐ Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosie Morningstar Howard L. Kolb ပ 19b. Mailing Address (Street and Number or Rural Route Nymber, City or Town, State, Zip Code) 10655 Bailey Springs Lane #25 Waynesboro, PA 17268 19a. Informant's Name/Relationship (Type. Print) Hilda Hoffman/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/14/2007 Frederick, MD Utica Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer FuneralHome, PA Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only ope cause of each light. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events ha to for as a consequence of Examine resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months 1 Yes 2 No Day Month Year 4☐Pregnant at time of death 9☐Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 246. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No ate has t page 2 s 24a. Was an autopsy performed? Ves 2 DNo certificate 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check onl o Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 1 ☐ Yes 2 ☐ No 10 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 🗌 Yes 2 🗌 No 2 Accident Director; 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

death with the Maryland Pages 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 and Mental Hygiene. Health a Department of H
Important: If Ite
any injury or ot Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours a

To the Funeral C

completely filled i 1 Certifying Physician: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and many er stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed death (Item 23a) (Type, Print) 455 TIL 1111 31. Date filed (Mo State 2007 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

found stank crobe 11 % brack Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic avant. It we Medical Examinat must be notified at

Physician

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For State Registrar		State	•		rtment of Health and M tificate of Death	_	Reg. No	4437	20637
1. Decedent's Name	(First, Middle	, Last)				2. Date of De Month		v Year	3. Time of Death
Howard	Κ.	Stone					. 2 .	2007	11:20pm M
4a. Facility Name (If	not institution,	give street and nu	mber)		4b. City, Town, or Location of Death		40	. County of Deatl	h
Manokin N	Manor N	ursing Ho	ome		Princess Anne			Somerset	
5. Social Security N	umber	6. Sex	7. Age (In yrs. last birth	day)_	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da	th v. Year	9. Birth	hplace (State or Foreign untry)
097-26-30	093	1) X(M 2□ F	94 Y	rs.	World Days Hours	12/18/	191	-	nsvlvania
Usual Residence of	Decedent								
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MD	Somer	set	Princes	25	Anne				1⊠Yes 2□No
10e. Street and Nur		000			10f. Zip Code		10g. C	itizen of What Co	untry?
11974 E	igehill	Terrace			21853			USA	
11. Marital Status	od 2 Mari	Armed F		13. W	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	cify Yes or No Rican, etc.))-	14. Race - Ame Black, White	

/Medical 4a. Facility Name Examiner Manokin 5. Social Security **Funeral** 097-26-Director Usual Residence 10a. State Director MD 10e. Street and N 11974 Completed by Funeral 11. Marital Statu 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑No Specify: Specify 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 U.S. Steel Steelworker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Stone Margaret Ellen Mahood ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frank Stone/Son PO Box 144, Princess Anne, MD 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Beechwood Cemetery 6/18/2007 Princess Anne, MD 22. Name and Address of Facility Hinman Funeral Home Signature of Funeral Service Licensee M00295 M00295 11673 Somerset Ave., Princess Anne, MD 21853
Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ASOND **Physician** /Medical Due to (or as a consequence of): Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 ☐ Probably 4 ☐Unknown Completed 24a. Was an autopsy performed 1 Yes 21 No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 VNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

attending physician and for use as the burial-transit Box 68760, Division of Vital Records, P.O.

Hospital or Attanding Pl 24 hours after death. Funaral Director: After the To the Hospital within 24 hours at To the Funaral D

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31. Date filed (Month, Day, Year) State Registrar

DR. USHA NATESAN

JUN 1 5 2007

enterch

29b. Signature and title of certifier

1415.5. DIVISION ST,

SALISBURY

29c. License number

005/359

29d. Date signed (Month, Day, Year) June 14th 2007

MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regetrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 0440 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Countyl of Death Examiner Dice a The WICOMI DUY Dal If Under 24 Hrs If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 1 F Months Davs Hours Min. 218-48-Dec. 24. Maryland Director Usual Residence of Decedent 10c. City, Town or Location death with the Maryland 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 PYes 2 □ No Director Mbridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 829 USA ark Lane 2/6/3 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. hours after 1 ☑Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within 72 l (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Military Academi Cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ၉ traumatic rida 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: if item 27 is any injury or other trau once. Cambridge, Maryland 21613 Flora Wongus 20e. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Church Creek, MD Old Field Cemetery 6/13/07 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Henry Funeral Home P. A. 510 washington St. Cambridg MD.21613 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (snes a consequence of) Examine burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical the attending pl 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 honths? 1 ☐ Yes No 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown iis certificate has been si director, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 217No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 1 Tyes 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 28a. Date of Injury 28h. Time of 27. Manner of Death 28c. Injury at Work? After t (Month, Day Year! 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

o the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after use.
the Funeral Director: Af within 2.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number

Name and address of person who completed cause of death (Item 23a) (Type, Print

(creal

32. Registrar's Signature 31. Date filed (Month, Day,

Medical

State Registrar

			For State	State of Maryland	-			Mental Hy	giene	
	_		■ Registrar		Cert	ificate of	Death		Reg. No.	1 2060
	Physic	ian	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day Year	
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	arylar show d at	<u></u>	10a. State 10b. County		Fown or Loca					10d. Inside City Limits 1 ☑Ŷes 2 ☐ No
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Maryland	ould be filed Mental Hygi arked other atic event, tl	o Be	2 11 2	aunders				elius	,	
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e,	S == 0	1 0	20a. Method of Disposition	20b. Plac	e of Disposit	ion (Name of tory or other pla	ce)	Date	20c. Location - City o	4 lon d 2 1144 r Town, State
E	Pages nent of I ant: If ite	١.	1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State Bet	1 1	?eneter		11/07	Cambri	Lee MD.
Baltimore	permit. Page Department o Important: If any Injury or any Injury or once.		21. Signature of Funeral Service License		22.1	Nama and Addre	of Facility uneral			1
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Вох	leath certific attending p for use as	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome pf pregnance 1 ☐ Live birth 2 ☐ Fetal de		ctopic pregnanc	у		23d. Date of de Month	
0.	the a	Physician/Me	1 Yes 2 No	4□Pregnant at time of deat 9□Unknown	th 5□0	Other (specify) _			WOTH	Day Year
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Division	l or Attend after death Director; /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At home building, etc. (Specify)	, farm, stree	t, factory, office		28f. Location (S City or Tow	treet and Number or F	Rural Route Number,
	ital o irs afi ral D									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medicai Examli	ician: To the best of my knowle ner: On the basis of examination	edge, death o n and/or inve	ccurred at the til stigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	as stated. le to the cause(s)
	thin 2 the othe	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signed (Mor	
	or with the second sec			100	PAL		24721			
			30. Name and address of person who co	mpleted cause of death (Item 23	Ba) (Two Dr		/4-T/41		June 6, 2	.007
			Syed Akbar Ali Sa	·		•	e Road,	Laurel	MD 20708	
	Sta	_	31. Date filed (Month, Day, Year)	32. Regierar's Signature	е	halle				
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Jermaine Lamont Smith

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15-0036 Elled within 77 Hygiene. d other than	ပို		John R.			r.							e1 "	Wilke			7.4	
121 d be fi ental arked	Be	1	a. Informant's Name/					19	b. Mailin	g Address	(Stree	t and Nun	nber or R	ural Route	Number,	City or Tow	m, State,	Zip Code)
Should and Mer is man	P		Mabel Smit			ther			9710	Dorv	al A	we.	Uppe	r Mar	lbor	o, Ma	ryla	nd 20735
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland not of Health and Mental Hygiene, nn: If item 27 is marked other than "natural", or items 23a or 28a-f she nn: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	1		a. Method of Disposi		,		T	20h Place	of Dispo	sition (Nan	ne of cer			Date	20	c. Location	- City or	Fown, State
Fe, ss 1 an of He If ite		1	X Burial 2	Crematio	on 3	Removal	from State			ther place)			6/1	3/07		Suitla	ind .M	aryland
Page nent cant:		4	Donation 5	Other	Specify:			Ceda	r H1	11 Ce	Address	s of Eacili	ty	5707		<u>are</u>	,	
Baltimore, MD 21215-0036 pennit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fshou injury or other traumatic event, the Medical Examiner must be notified at once.	:	17	. Signature of Funera	/	1 /	I/	1		1 -	F 20 1/			U 3 170	P.A. For	A G I V	7ille.	. Md.	20747
 8 9 . []			Ba. Part I. Enter the d	10	0 12	ملك وموند	ot caused the	death Do	not enter	the mode	of dying.	, such as	cardiac o	r respiratory	arrest,	shock, or he	eart	Approximate Interval Between Onset and
ysiciar	יַ	23	Ba. Part I. Enter the di failure. List only	iisease, i one caus														Death
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68 certif	Se as	<u>اةِ</u>	past 12 months?			4 P	regnant at tim	e of death		Other (Sp					_	ł		
Box 68 e death certif	101	Physician	1 Yes 2 No	9	Unknown		nknown						Dort	23e	Did toba	cco use co	ntribute to	the cause of death?
· >-	ached		Part II. Other signific	cant cor	ditions	contributi	ng to death b	ut not resu	Iting in th	ne underlyi	ng cause	e given in	Part I.					obably 4 Unknown
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of Vital Records, g Physician: The law requir ther this certificate has been s	page	Completed									26.Pla	ace of Dea	ath (Chec	k only one)				
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this Sie	al dir	0	1 ✓ Yes 2			282	Date of Injury	, 2	8b. Time		28c. li	njury at W	/ork?			w injury oc	curred	
ing P	uner		27. Manner of Death 1 Natural			FO	Month, Day,Yea	ır) F	FOUND	:	1	Yes 2	✓ No	Subjet				
ion tend eath tor:	the	atic	2 Accident		Pending Investigation	lur	6, 2007 Place of Inju	1 (0305 hrs	street, fact	orv. offic	e building	g, etc.	28f. Loc	ation (S	reet and Nu	umber or	Rural Route Number, Cit
Division tal or Attendi	in by	iji ji	3 Suicide		Could not I	oe			, 10/111,	- 1 04 1001	,,			0 T	COURS St	ate) venue, Clii		
ital (filled in	Certification:	4 V Homicide		determined		ecify) Side				the *:	date an	d nlace a	and due to th	20 021186	(s) and ma	nner as s	tated.
Host 24 ho	stely		29a. Certifier 1	Certifyir	ng Physici	an: To th	ne best of my	knowledge ination and	e, death o d/or inves	sccurred at stigation, in	my opir	nion, deat	h occurre	d at the time	e, date a	ind place, a	ind due to	the cause(s)
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certifi	completely	Medical				and ma	nner stated.				29c. Lin	ense num	nber			29d. Date	signed (i	Month, Day, Year)
FSF	ប័	ž	29b. Signature and	title of c	ertifier ~	1~	100-	V 10				.C.M.E.		OCM	E	June 6,	2007	
			('al	ro	t x	1-11	LUC	CV										
R 12)		30. Name and addre		erson who	complete	d cause of de	eath (Item 2	23a)	nn Stree	of Rali	timore	MD 21	201				
1			Carol Allan,	MD	Assista		dical Exam				, Dal		21					
	s	tate	31. Date filed (Mon	th, Day	007	A.	32. Registrar	's Signatur	ford									
Re	gis	trar	ן אטנ	126		100	w /	7.										

P.O. Box 68760, Division or Vital Records,

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

REDERICK

Medical

State Registrar

31. Date filed (Month, Day, JUN 2 6 2007

400

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene / Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year homas 0 2007 6:00 M 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) of University Maryland Baltimore Medical 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Days 1 ▼M 2 □ F 83 July 23, 1923 Washington, DC 577-20-2805 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 XNo MD Calvert County St. Leonard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20685 U.S.A. 5712 Mackall Road 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Graphic Communications College (1-4or 5+) Elementary/Secondary (0-12) International Union 8 Union President 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella May Weigel Thomas Walter Treynor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 126, St. Leonard, Maryland 20685 Carol T. Bowen (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 12. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 2007 Clinton, Maryland 21. Signature of Funeral Service Livense 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Michael W. 1 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Preumonia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or irjury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 WUnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death? 1 ☐ Yes 2 No Yes 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Department of Health an Important: If Item 27 Is any injury or other trau

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

items

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Director

Funeral

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Completed

Be

Examiner

Completed by Physician/Medical

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Medical Certification: To

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

and Mental Hygin Is marked other

Itimore, Maryland 21215-0036

attending physician

bital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

Division or Vital Records, P.O. Box 68760.

State

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 1 ☑ Natural 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide determined t Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P-21195

6/10/07

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore

Registrar

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

nester fravers		- For State - For State - For State - For State - Certificate of Death	_	Reg. No.	2007 2054
Physician ledical Examine	7	1. Decedent's Name (First, Middle,Last) Chester William Travers	2. Date of Dea	Dav Ye	3. Time of Death
Jedicai Examine		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Truitts Landing Salisbury	June 19,	4c. County Worces	y of Death
Funeral Director		5. Social Security Number 212-72-1498 6. Sex 17. Age (In yrs. last birthday) 48 17. Ag	_	irth(MM/DD/YYY -1959	(Y) 9. Birthplace (State or Foreign Country) Maryland
ow any	4 -	Usual Residence of Decedent 10a. State			10d. Inside City Limits 1 X Yes 2 No
after death with the Maryland al", or items 23a or 28a-f show here must be notified at once.	Director	10e. Street and Number 206 Ironshire Street 21863		10g. Citizen of V	/ 3
ath with the items 23a of the state of the s	ᇎᅡ	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (S		o- 14. Rad	ce - American Indian, Black, nite, etc.
nurs after de	d by Fune	Widowed 4 Divorced ITYS, Give Year Unknown 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		Specify	White Business/Industry
215-0036 be filed within 72 hours and Hygiene ent, the Medical Exami	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 none Laborer			struction
21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica	e l		Messick		
MD 21 d 2 should d 2 should lith and Me n 27 is ma aumatic ev		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Z06 Ironshire Street	, Snow	Hill, M	D 21863
Baltimore, MD 21215- permit. Pages 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked of injury or other traumatic event, the		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Olivet Cemetery 6/	Date 22/2007		n - City or Town, State Maryland
Balti permit. Departir Importir injury	(1. Signature of Funeral Service Licensee M00295 M00295 M00295 Ave	Prin	cess An	ne, MD 21853
Physician Medical Examiner	4	23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. Immediate Cause (Final disease a. Drowning complicating acute alcohol intoxica		rrest, shock, or h	Approximate Interval Between Onset and Death
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of):			
		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):			
xecuted and I - transit	calEx	d			
ox 68760, saft certificate be executed attending physician and or use as the burial - transit		#Z3a,Z7,Z8a-T, perVIE, g808, 6/2//0/ TI	agnov	23d. Date Month	of delivery Day Year
0 0	Physician/	23b. Was decedent pregnant in the past 12 months? 1	lancy	i vicinar	Bay Tour
P.O. E es that the digned by the be detached	ò	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ntribute to the cause of death? 3 Probably 4 Unknown
cords, P	Completed		per	opsy formed?	b. Were autopsy findings available prior to completion of cause of death?
Vital Rec ysician: The I his certificate I director, page		25. Was case referred to medical 26.Place of Death (Check	1 Yes	3 2 No	1 Yes 2 No
· Vita	To Be	Yes 2 No	ing Home 5		Other: Scene
ion of tending Pheat.		27. Manner of Death 28a. Date of Injury (Month, Day,Year) 1 Natural 5 Pending (1.2007) 6/19/2007	1	e how injury occ ct drowned	
Division ospital or Attend hours after death meral Director: y filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 X Could not be		(Street and Nur	mber or Rural Route Number, City
Di lospital 4 4 hours a		4 Homicide determined (Specify) bay 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place of the control of the contr	Truitt	s Landing	Salisbury, MD
To the 110s within 24 h To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, da	te and place, and	d due to the cause(s)
	Ž	29b. Signature and title of certifier 29c. License number O.C.M.E.		June 20,	igned (Month, Day, Year)
		30. Name and address of person who completed cause of greath (Item 23a)			
		Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M 31. Date filed (Month, Day, Year) 32. Registrar's Signature	1D 21201		
Sta Registi		JUN 2 2 2007 Sleave & Sparker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

Physician	
/Medical	
Examiner	

Director

Completed by Funeral

Be

Funeral Director

ral", or items 23a or 28a-f show Examiner must be notified at 2 should be filed within 72 hours after and Mental Hygiene. traumatic event, the Medical permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun once.

3altimore, Maryland 21215-0036

Physician /Medical Examiner The law requires that the death certificate be executed

for use as the burial-tran attending physician signed by the a d be detached for certificate has b After this within 24 hours after death To the Funeral Director; filled in by the

P.O. Box 68760,

Division or Vital Records,

or Attending Physician;

Hospital

Physician/Medical Examiner

Completed by

Be

Medical Certification:

Meena Shah, MD 31. Date filed (Month, Day, Year)

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Maurice Tyler 1736 lune 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical Center Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Months Days Hours **™** M 2□ F 220-52-0173 58 June 6, 1949 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Dorchester Cambridge 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 824 Locust Street 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. white Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) manager restaurant unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cecil Tyler Laurena Creighton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tonya Faulkner daughter 5331 Chateau Road, Cambridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/14/07 Dorchester Mem. Park Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure
Due to or as a consequence of): ho disease or condition resulting in death) Neuromuscular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Spinal Abscess Due to (or as a consequence of) Osteomyelits IF FEMALE 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □ Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Fibrillation with Rapid Venticular 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Intechor 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 □Pending investigation 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD June 11, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Balhmore, MD 21201

22 South Greene Street

32. Restrar's Signature

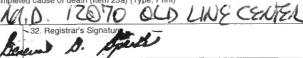
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 8, 2007 Year 2:47 A **Physician** Callie Virginia Thomason /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Waldorf Charles Genesis Waldorf Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 16, 1915 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6 Sex **Funeral** Months Days Hours North Carolina 1 □ M 2X 1 F 578-44-2285 91 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c, City, Town or Location r 28a-f show notified at 10a, State 10b. County 1 ☐ Yes 2 No 'irginia Arlington Arlington Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō USA other traumatic event, the Medical Examiner must be 4201 S. 31st Street 22206 #730 death v items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∰No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify: þ 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Retail Cashier 12 should be filed w h and Mental Hygie 7 Is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Griffin Martha John Rhyne ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) is 1 and 2 s of Health an item 27 is i 4201 S. 31st. St. Arlington, VA. 22206 Catherine L. Webb/Daughter Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of Inportant; If ite any Injury or ot 1XBurial 2 □ Cremation 3 □ Removal from State 06/11/2007 Suitland, Maryland Washington Nat. Cem. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signatu of Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland 20745 tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest course on each line. Approximate Interval Betwe Onset and De 23a. Fart1. Enter the disease, or complic thock, or heart failure. List only on Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the burla Physician/Medical 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 5 Other (specify) ed by the a 9☐Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2□No certificate 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1.₩Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier within 24 hor To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) WALROLF, Md. 2002

State Registrar

31. Date filed (Month, Day,



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. ANEXE OF MANUARD DEPARTMENT OF HEALTH WIND MENTAL Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jun 14, ^{Day} 2007 **Physician** 8:20am **Torrington** Maryann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland Allegany Co. Nursing & Rehab Ctr. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Feb 14, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□ M 2**X** F 1924 212-24-0665 83 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant; If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Cumberland 1 ☐ Yes 2 ☐ No MD Allegany Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 635 Washington Street Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Armed Forces? 1 **X**) Yes 2 ☐ No If Yes, Give Year or Dates: **WWII** 1 Never Married 2 Married 1 □ Yes 2 □ Xo Baltimore, Maryland 21215-0036 Specify: white 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 2+ own home 12 homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be McMullen Jacob Helen William Jacob ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 4 Vocke Drive LaVale W. James Torrington son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State 6/19/2007 MD SS Peter and Paul Cemetery Cumberland 4 Donation 5 Other (Specify) 21. Signature Fundral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immedia Cause (Final END STAGE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician certificate be Physician/Medical IF FEMALE: use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year for 4□Pregnant at time of death detached the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform has 2 No 1∐ Yes Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Inpatient 2 ER/Outpatient 3□ DOA 2 27. Man of Death 28c. Injury at Work? To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2007

State Registrar

DHMH 17 Rev 1/2001

5

2. Registrar's Signature

BARRERA, JR., M.D.; MEM HOSP. MED. BLDG. CUMBERIAMO

30. Name and address of person who completed cause of death (Item 23a) Type, Print)

31. Date filed (Month, Day, Year)

ROBUSTIANO J.

JUN 2 6 2007

State of Maryland / F	Department of Health	and Mental Hygiene
Otate of Maryland / I	Department of Health	i and Mental Hygierie

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 11 MILDRED Year O Month **Physician** VANSICKLE 6 1300 M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany County Nursing & Rehab Ctr. Allegany Cumberland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ☐ M 2 💢 F Director 217-14-4070 02/21/1924 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State ahow 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28e-f ahov the Medical Examinar must be notified at MD Allegany Cumberland 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 229 Baltimore Avenue 21502 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify. 3 Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nurse Assistant Nursing Home permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Importent: If item 27 is markad other any injury or other treumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles William Cross Bessie Marion Free 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3700 Ralph Road, Silver Spring, MD 20906 Linda D. Foo / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Vet. Cem @ Rocky Gap 06/15/2007 Flintstone, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DEMENTIA 10 years resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) the ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2. No 3 Probably 4 □Unknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 Yes a No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Tes 22 No Other. Unursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending efter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours e To the Funerel I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) tha 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 053853 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 131 PENNSYLVANIA AVE, CHMBERLAND, MD21502 nds A. CHOTANI HABIB 31. Date filed (Month, Day, Year) 32. gistrar's Signature State JUN 1 2 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Mary Ann White /Medical June 16, 2007 5:15 P. 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner WMHS-Frostburg Nursing & Rehab Ctr. Frostburg **Allegany** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 M 2 X F Director 216-38-1799 96 AUG. 1, 1910 MARYLAND Usual Residence of Decedent r 28a-f show notified at 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits 1 ☐ Yes 21 No Director MD ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r 89 BEALL STREET EXTENDED 21532 U.S.A. death v Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ Specify: 3 XWidowed 4 ☐ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HEAD START TEACHER'S AIDE iled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be finance and Mental H Be DOUGLAS PAIGE ROSA REDMAN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 135 ORMOND STREET, FROSTBURG, MD s 1 and 2 of Health a item 27 SYLVIA WHITE / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ortant: If ite 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or 4 Donation 5 Dother (Specify) FROSTBURG MEML. PARK 06/21/2007 FROSTBURG, MD 21. Signature of Funeral Service Lic Name and Address of Facility
HAFER FUNERAL SERVICE, P.A. 1302 NATIONAL HIGHWAY, LAVALE, MD complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 21502 23a. Part 1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final Physician Coronary Artery Disease
Due to (or as a consequence of): disease or condition Years /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-tran certificate be exect Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 X No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a P.O. 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Diabetes Mellitus & Bladder Tumor; Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 : certificate has autopsy 1☐ Yes Division or Vital 2 **X** No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3□ DOA ٩ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

73

State 31. Date filed (Month, Day, Year)
Registrar

Jesus Tan, M.D.,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

4 Broadway, Frostburg,

D21244

MD

21532

June 18,2007

burial-trar Division or Vital Records, P.O. Box 68760,

2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death THOMAS JUNE 20 2007 ARTHUR WHEAT, SR. 7:12 p^M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Chester River Hospital Chestertown Kent If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV 7 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 X M 2 □ F Maryland 76 213-22-8202 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 2 Yes 2 No Director MD Chestertown Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 105 Clipper Way 21620 U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Ite any injury or other traumatic event, the Medical Examines 1 Never Married 2 M Married 1 ∐ Yes 2 📉 No If Yes. Give Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Car Salesman Car Sales 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robie James Wheat Dorothy V. Haque 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara George (daughter) 417 Wood Lane Denton, MD. 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 6/25/07 Kent Cremation Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Chineral Service Licensee 22. Name and Address of Facility
Galena Funeral Home of Stephen L. Schaech 21635 M00510 118 West Cross St. Galena, MD. Approximate Interval Between Onset and Death Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heal failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Years ASCUD /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ ATTIAL F.Brillar 1 Yes 2 No 3 Probably 4 Unknown Completed type Tongion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Myperhoisin Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ☐ ER/Outpatient 3 ☑ DOA ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

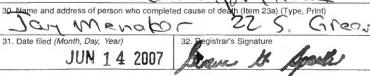
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JEFFRY VIEWS MO 1) 63747 dress of person who completed cause of death (Item 23a) (Type, Print) 2540 Centreville Rd. Centreville, MD. Jeffery Ukens, M.D 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 2 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ath 2007 Month **Physician** 1356 DM kenn orle. Unc /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b_City, Town, or Location of Death Examiner gramit 1 niversit Mon low 0 BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Sex 1 M Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Min. Days Hours 2 🗆 F MARCH 24, 1955 Director 216-58-5013 52 MARYLAND Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MARYLAND QUEEN ANNE'S **STEVENSVILLE** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 727 KIMBERLY WAY 21666 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ANNE ARUNDEL Elementary/Secondary (0-12) College (1-4or 5+) 9 COUNTY EQUIPMENT OPERATOR permit. Pages 1 end 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) with and Mental F. CLARENCE RANDOLPH WORLEY ဨ MARIAN CONSTANCE RECTOR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CONNIE WORLEY/WIFE 727 KIMBERLY WAY, STEVENSVILLE, MARYLAND 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State JUNE 14 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION 2007 STEVENSVILLE, MARYLAND 21. Signalure of Funefal Service License FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part1. Enter the disease, or complications that reused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** recenta 12 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner death certificate be execut burial-trar Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the as attending IF FEMALE: use a 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery lor 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ cate has been sig page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒ No 24a. Was an certificate has autopsy performed? 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Hospital or Attending Pl 24 hours after death. Funeral Director: After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 □ Natural 2 □ Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) JUN 14 2007



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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** HILDA M. WARRINGTON JUNE 12 2007 3:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomios REGIONAL MADINAL SULISBURY Peninsula Conter If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 F F 91 FEB 9, 1916 218-50-2069 DELAWARE Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director GEORGETOWN DELAWARE SUSSEX 28a-f 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ò 22423 LEWES-GEORGETOWN HIGHWAY items 23a 19947 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 'natural", or 1 ☐ Yes 2 🛣 No Specify: WHITE þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 10 nand Mental Hygin 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be GEORGE S. QUILLEN LAVINA LYNCH ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar Important: If item 27 is any injury or other trau MARIE W. ROGERS / DAUGHTER 22423 LEWES-GEORGETOWN RD, GEORGETOWN, DE 19947 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 Cremation 3 Removal from State ST GEORGE'S CEMETERY 6/16/07 4 □ Donation 5 □ Other (Specify) CLARKSVILLE, DELAWARE 22. Name and Address of Facility WATSON FUNERAL HOME 211 S. WASHINGTON ST, MILLSBORO, DELAWARE 19966 21. Signature of Funeral Service 23a. Part1. Enter the disease, or comples shock, or heart failure. List only one ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician UMONI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. E. its fundaring Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-transit and Due to (or as a consequence of): physician Physician/Medical the attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) led by the a detached f 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Donknown page 2 should Completed NFECTION 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No RINARY 24a. Was an certificate has autopsy perform 2 No 1□ Yes 2 No Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 TYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation hours after death. uneral Director: A 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospitai or Attending within 24 hours a To the Funeral C

Maryland 21215-0036

Baltimore,

Box 68760

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Records,

Division or Vital

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day,

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

·//-IMWARAYAPRA 614 EASTERN JUN 1 3 2007

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

STONE DE

29d. Date signed (Month, Day, Year)

		_	For State Registrar	State	of Marylar			of Health of Deati		F	leg. No.	007	20	552
	Physicia		1. Decedent's Name (First, Min Bessie Marie							2. Date of Dea Month June 1	Day	Year	3. Time of I	P ^M
	/Medid Examin	er	4a. Facility Name (If not institu	ition, give street and		1	4b. City, Tov	wn, or Location	n of Death			unty of Death		
	Funeral Director		5. Social Security Number 214-74-5863	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs.	. last birthday)	If Under 1 Y Months D	Year If Undo	er 24 Hrs. Min.	8. Date of Birth (Month Day Oct. 3,	1906	9. Birthp Cour Mary	lace (State or Land	r Foreign
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene item 27 is marked other then "netural", or Items 23e or 28a-f show other treumatic event, the Medical Examination until be notified at	d within 72 hours after death with the Maryland jiene ir then "netural", or Items 23e or 28a-f show ir then "netural", or Items 23e or 28a-f show the Modical Examination to Invitie as	Completed by Funeral Director	10e. Street and Number 827 Bill Beit: 11. Marital Status 1 Never Married 2 3 XWidowed 4 Divor	zel Rd. 12. Was D Armed 1 Yes, Year. Ident's Education Inghest grade complete	21536 US Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:					14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry Own Home				
	2 should be file and Mental Hy is marked oth eumatic event	To Be (17. Father's Name (First, Mid Jacob Fazenbal 19a. Informant's Name/Relat	ker tionship (Type, Print)				Eli Street and Nun	iza Bu	e (First, Middle, arkholde al Route Numbe	e r er, City or T	own, State, Zij	_	
Baltimore, IV	Page ient o nt: If		Freda W. Warn 20a. Method of Disposition 1 X Burial 2 Cremat 4 Donation 5 Othe 21. Signapare of Funeral Ser	ion 3 □Removal fr ar <i>(Specify)</i>	20b.	Place of Dispo cemetery, cre ittinge	osition (Name matory or othe r Ceme	of er place) tery J	June 1	consvill Date .8, 2007 Man Fur	20c. Loca Bitt	inger,	own, State	
Pnysicia /Medica Examine	rnysician /Medical Examiner	i Examiner	23a. Part1. Er(er the diseas shock, or hear failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a Due		ath. Do not en aquence of):	.O. Bo	x 275, of dying, such	Grant	sville	MD	21536	Approximatinterval Bet Onset and I	ween Death
P.O. Box 68/60,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1	o, outcome of pregive birth 2 □ Fe tregnant at time of Inknown	etal death 3	□Ectopic prec □ Other <i>(spec</i>				23	d. Date of delive	,	Year
	w requires that t been signed by should be detac	ed by Ph	Part If. Other significant con	nditions contributing	to death but not re	esulting in the	underlying cau	use given in Pa	art I.		obacco use	ocontribute to		death? Unknown
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Division of Vita	or Attending Physicien: Th after death. Director: After this certificate in by the funeral director, pag	Certification: To Be	2 Accident In	Hospital: 28a. E ending ivestigation outld not be committed 28e. F	1 Inpatient 2 Date of Injury (Month, Day Year) Place of Injury - Al building, etc. (Spe	t home, farm, s	of 28	Other: 4 C. Injury at Work?] Nursing H	th (Check only ome 5 Resized R	dence 6 how injury	occurred		nber,
	To the Hospital or Atter within 24 hours after de To the Funerel Directo completely filled in by the	edical Co	29a. Certifier 1 Can (Check only 2 Mar one)	rtifying Physician: T dical Examiner: On t and	o the best of my k the basis of exam manner stated.	knowledge, dea ination and/or i	ath occurred at investigation, i	t the time, date in my opinion,	e and place death occu	, and due to the rred at the time,				s)
)	To the within 2 To the comp	Me	29b. Signedire and title of co	existien da	un 1	0		D266				signed (Month		
			30. Name and address of per	Kaiser 1	ud 13	tem 23a) (Type	e, Print)	highw	ay o	aklar	rel, l	id at	550	
:	Si Regis	tate trar	31. Date filed (Month, Day,	2 0 2007	32. Registrar's Sig	gnature ()	Seach s	J						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year George William Wagner JUNE 2007 18 1700 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months 1/**X**M 2∏ F 83 Mary Land 220-16-6286 July Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD. Allegany Westernport 1XXes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Kalbaugh 21562 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No WW 2 Specify: white 1 ☐ Yes 2 ☑ No Specify: 3€Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Retail Elementary/Secondary (0-12) College (1-4or 5+) Pharmaceutical Pharmacist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Wagner Genevieve Berry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Wagner/ son 14300 44th Ave. N, Plymouth, MN. 20b. Place of Disposition (Name of cemetery, crematory or other place) MD. Veterans Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Flintstone Marvland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on peach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ngestive Heart Failure if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performe 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be determined

Examiner requires that the death certificate be executed burial-trar Division or Vital Records, P.O. Box 68760, physician the as attending asn for ed by the a detached f signed by page certificate Physician: funeral director,

Physician

/Medical

Examiner

Funeral

Director

show

an "natural", or Items 23a or 28a-f shov Medical Examiner must be notified at

the

7 is marked other traumatic event, the

Pages 1 and 2 should be fill ment of Health and Mental H cant; If item 27 is marked out

Department of Health Important: If item 27 any injury or other to

Physician /Medical Director

Funeral

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Completed

Be

Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

death with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore,

After this Hospital or Attending death. within 24 hours after death

To the Funeral Director:
completely filled in by the

10 +IVA

Eyasu Mekonen mp Eyasu Mekenen
31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

29a, Certifier (Check only

4 ☐ Homicide

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Drive Cumberland, Maryland 21502 900 Seton

State Registrar JUN 20 2007

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 08:51 AM 2007 10519 09 06 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner PLEDICAL)ALISBURY WICHMICO KEGIONAL CENTER ENINSULA 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number **Funeral** 214-348560 Months Days Hours 1 □ M 2 1 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ntant: If item 27 is marked other than "naturai", or items 23a or 28a-f show injury or other traumatic event, the Medical Examinet must be notified at 1 Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 863 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) per it. Pages 1 and 2 should be I De Intment of Health and Mental I Important: If item 27 is marked o Jessic nomus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOGNNO 20b/ Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 2 ACremation 3 □ Removal from State Date 4 Donation 5 Dother (Specify) 2). Name and Address of Facility R of Traveral Service Licensee Salish Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner the death certificate be executed Вох IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 → Nown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 1∐ Yes 2 1100 Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be 1 Tes Hospital: Other: _2__No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐Other (Specify) 27. Manner of Death Date of Injury 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 5 ☐ Pending investigation (Month, Day Year) Division Injury 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E Carroll St. P. O. Salisbury, Eng, Simona 31. Date filed (Month, Day, Year) 32 Begistrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

				State of Marylai		ent of Health and ate of Death		21111	20655	
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	/Medi	cal	4A Fecility Name (If not institution, give	WATERS)	4h City Town o	6 - 9	5-2001	1230	
J	Exami	ner	4571 SPRIN	JA JANE		NAWT	TOKE	4c. County of Death	ica	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	Month	ler 1 Year If Under 24 Hr s Days Hours Mir	s. 8. Date of Birth		place (State or Foreign ntry)	
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	show	_	10a. State 10b. County	10c. Ci	ity, Town or Location	Je F			10d. Inside City Limits	
	the M	recto	10e. Street end Number	100 1	JAN IICC	ip Code	100	Citizen of What Cou	1 ☐ Yes 2 No	
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_	ter des terre	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces?	J,S. 13. Was Dec If Yes, sp	edent of Hispanic Ongin? (ecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri Black, White,		
070	ours of rel', or Exem	by	3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes	2 No Specify:		Specify: N	ACK	
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	s 1 end 2 should if Health end Mer item 27 is merks other traumatic		EUGENE WATE	is nephew	9111 201	LING VIEW	LANH	AMM	20106	
Baltimore,	e = 5 0		20a. Method of Disposition 1	Removal from State	Place of Disposition (Notemetery, crematory of	ame of other place)	Date 20c.	Location - City or To	own, State	
altin	permit. Pe Depertmer Important: any injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		HITICOLE ()	and Address of Facility	6401 W	AN HOUT	IF, MID	
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			23a. Part1. Enter the disease, or compleshock, or hear) failure. List only or	ications that caused the deal ne cause on eech line.	th. Do not enter the mo	ode of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between	
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of Vital Records,	The law requires that the death certificate be execute hes been signed by the ettending physician and page 2 should be deteched for use as the bunial-treat	ted b					24a. Was an eut	av	ere autopsy findings ailable prior to	
360	elawr hesbe je 2sh	Completed						CO	mpletion of cause death?	
ta	ysician: The law is certificete hes b director, pege 2 s		25. Was case referred to medical			26 Place of De	ath (Check only one)	219110 1	☐Yes 2☐ No	
of Vi	× .00 C	ို	examiner? 1 Des 2 No		ER/Outpatient 3 0	Othor	Home 5 Presidence	6 ☐Other (Specif	iy)	
ono	Attending Physician: r death. sctor: After this certific by the funeral director,	ţon:	27. Manny of Death 1 Naturel 5 ☐ Pending investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred		
	or Attending effer death. Director: After I in by the fune	tifica	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Piece of Injury - At he	ome, farm, street, facto		28f. Location (Street a	and Number or Rura	al Route Number,	
	oftal or urs effe iral Dir illed in	Cer		building, etc. (Specif			City or Town, Sta			
	To the Hospital or Attending Ph within 24 hours either death. To the Funeral Director: After th completely filled in by the funeral	edicai Certification:	29a. Certifier (Check only one) 1 Certifying Physical Examination	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death occurred tion and/or investigatio	f at the time, date and place n, in my opinion, death occi	e, and due to the cause(urred at the time, date a	s) and manner as s nd place, and due to	tated. the cause(s)	
	To the Comple		29b. Signature and little of certifier		29	c. License number	29d. D	Date signed (Month,	Day, Year)	
						75097) 6	17/0)		
			30. Name end address of person who go	mplet of cause of deeth (Item	1 23a) (Type, Print)	175 U977 St.	Salah	my Mo	2801	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrer's Signa						

		1 - For State Registrar	State of Maryland	I / Department of Health and N Certificate of Death	Mental Hygiene	
Physic		1. Decedent's Name (First, Middle, Last)	Louise V	Vashinaton .	2. Date of Death Month Da	y Year 3. Time of Death
/Medi Examii		4a. Facility Name (If not institution, give s		4b. (W), Town, or Location of Death	40	County of Death
Funeral Director		5. Social Security Number 6. Sex 2 15 − 18 − 4115	7. Age (In yrs. Ia	st birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country) Mary Jand
aryland show		Usual Residence of Decedent 10a. State 10b. County		Town or Location		10d. Inside City Limits 1 ☐ Yes 2 ☐ No
or 28a-1	Funeral Director	10e. Street and Number	1	rappe 10f. Zip Code	10g. Cil	tizen of What Country?
r death with the	Ineral		2 Was Decedent Ever in U.S Armed Forces?	. 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc.
ours afte	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 1 No Specify:		Specify: Black
ILLID-0030 filed within 72 hours after Hygiene. ther than "natural", or ite int, ire Medical Examina	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing 16b. K	IF Employed
TICA C	Be	17. Father's Name (First, Middle, Last)	01	A A	e (First, Middle, Maiden	
VICELY ICE 12 should h and Men 7 le marke traumatic	J.	Josiah 19a. Informant's Name/Relationship (Typ	ا با	19b. Mailing Address (Street and Number or RV)	al Route Number, City o	
Desitified by War ylating ZIZID-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or items 23s or 28s-1 ehow any higher or other traumatic event, its Madical Examinar must be notified at angle.	j. 6	20a. Method of Disposition 1 Burial 2 Cremation 3 Re	emoval from State	5/48 - Ocean gate W lice of Disposition (Name of metery, crematory or other place)	Date 20c. Lo	o ation - City or Town, State
Dalling permit. Pages Department of Important: If i any injury or once.		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		22. Name and Address of Facility HENRY FUNERAL	Home, P. A	appe, Maryland
		shock, or heart failure. List only on	cations that caused the death.	Do not enter the mode of dying, such as cardiac	to Cambri	Approximate Approximate Interval Between Onset and Death
Pnysician /Medical Examiner	1	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque	resolve	Heart	dezest.
e on a set	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the cause of the ca	Син to (от яв я сопведие	ance of):		
of ou, sate be executed hysician and the burial-transit	I Examiner	that initiated events resulting in death) Last	Due to (or as a conseque	ance of):		
BOX GOL	Medica	IF FEMALE:	111.70°-00-00	= 18:		
The COLOGS, F.C. BOX 00/00, The law requires that the death certificate be executed to has been signed by the attending physician and sage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dead 9 ☐ Unknown	death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
ires that the signed by	Ď	Part fi. Other significant conditions con	tributing to death but not resul	ting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
lecolus, law requires has been sign e 2 should be	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
rician: The sertificate ector, pag	Be Col	25. Was case referred to medical examiner?			performed? 1 ☐ Yes No h (Check only one)	death? 1 □ Yes 2 □ No
ing Physi	lon: To	27. Manner of Death 1 Natural 5 Pending		b. Time of 28c. Injury at Work?	ome 5 Residence 28d. Describe how inju	
or Attend fler death director: ,	Certification:	2 Ascident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No ne, farm, street, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number, 9)
To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	er: On the basis of examination	ledge, death occurred at the time, date and place, on and/or investigation, in my opinion, death occur	and due to the cause(s red at the time, date and) and manner as stated. d place, and due to the cause(s)
To the within 2 To the compleil	Med	29b. Signature and title of certifier	and manner stated.	29c. License number		te signed (Month, Day, Year)
		30. Name and address of person who con		23a) (Type, Print)	7 0	C, MD-21613
Sta	ate	31. Date filed (Month, Day Year)	32. Registra's Signatu	503134RN STO G	MU164(1) G	E, MD-24615

DHMH 17 Rev 1/2001

4b. City. Town, or Location of Death

Silver Spring

4a. Facility Name (If not institution, give street and number)

9900 Georgia Avenue

Washington,DC

Funeral

Examiner

The law requires that the death certificate be executed sician and burial-tran physician the burial attending pl cate has been signed page 2 should be det certificate To the Hospital or Attending Physician: funeral director, After this 24 hours after deat Funeral Director; completely within 24

If Under 1 Year | If Under 24 Hrs. 5 79 - 58 - 1866 **578 - 82 - 9252** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1,∏ M 2 □ F Director 64 2/11/1943 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County MD Montgomery Silver Spring Directo 10e. Street and Number 10f. Zip Code 9900 Georgia Ave 20902 Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 Tyes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1X Never Married 2 Married 1 □ Yes 2 If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Specialist Printer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Sinclair Wade Annabelle Virginia Meadows ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Demetrius Crawford/Son 15106 Derbyshire Way, Accokeek,MD 20607 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 16°, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD National Resurrection 6/15/2007 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 and 2 a. Part1. Enter the diseas Part1. Enter the diseas a continuous that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) UN **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by autopsy performed 1∐ Yes 25. Was case referred to medical Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation (Month, Day Year) 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10d. Inside City Limits 1 XYes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. Specify: African Am. 16b. Kind of Business/Industry Federal Government Clinton, Maryland Laure1 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

20037

State Registra IMAD

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TABBAR

MD

Registrar's Signatur

MD18948

2150 Pennsylvania Ave NW, Ste 3-428, Washington DC

State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Heal State Registrar State of Maryland / Department of Heal Certificate of of He		, ,	ene 3. No.2 0 0 7	20550
表	Dharist		1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year	3. Time of Death
Ю	Physicia /Medic		Edward Webster		June	6 2007	5:15a M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	ocation of Death		4c. County of Dea	th
			Clinton Nursing Home Clinton			Prince G	eorge's
	Funeral		Months Days I	f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
ı.	Director		5/9-16-5165		06/03/2		ginia
	pur M		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	sho sho	5					1 √2 Yes 2 □ No
	he N 28a-f otifie	ecto	D.C. Washington 10e. Street and Number 10f. Zip Code		140	g. Citizen of What Co	**
:	a or 3	ä	10e. Street and Number 1207 Alabama Avenue, S.E. 200	132	10	USA	ountry?
	s 23	eral			asifu Vac ar Na	14. Race - Ame	arican Indian
36	be flied within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	Armed Forces? If Yes, specify Cuban, I □ Never Married 2 Married 1 □ Yes 2 ♣ No	Mexican, Puerto Specify:	Rican, etc.)	Black, White	
21215-0036	tura sal E		15. Decedent's Education 16a. Decedent's Usual Occupation	on	1	 6b. Kind of Business	/Industry
5	in 72 n "na Nedic	plet	(Specify only highest grade completed) (Give kind of work done durit	ing most of work	ing		,
12	with jiene tha the N	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 11 Sexton			Church	
0	other other	Be C	17. Father's Name (First, Middle, Last)	8. Mother's Name	e (First, Middle, M	aiden Surname)	-
<u>a</u>	lould be to the total to the total to the total to the total	To B	Irvin Ralph Webster	Louis	e Tinsle	У	
Maryland	12 should be filed v and Mental Hygie is marked other t raumatic event, th	-3	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and	d Number or Rur	al Route Number,	City or Town, State,	Zip Code)
ž	alth a 27 is 27 is	٠.,	Juanita Watkins/Daughter 1207 Alabama Av	ve., SE,	Washing	ton, DC	20032
ē,	s 1 a if Hei item othe		20a. Method of Disposition 20b. Place of Disposition (Name of			0c. Location - City or	Town, State
E .	Page ento nt: If ny or		1⊠ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Cemeter	v 06/	11/07 H	Brentwood,	MD
altimore,	nit.		21. Signature of Funeral Service Licensee 22. Name and Address of		, ,	n Funeral	Home
ñ	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		3401 Bladens				20722
	0.00		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.	such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician	9.2	Immediate Cause (Final Hopato Collular Carcinoma				Onset and Death
4	/Medical		disease or condition resulting in death) Due to (or as a consequence of):				
4	Examiner		Right Chest Wall Absess				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):				
·	cuted d ansit	Examiner	Cause Disease or injury that initiated events c.				
oʻ	exection and and and and and and and and and an		resulting in death) Last Due to (or as a consequence of):				
68760,	icate be executed physician and s the burial-transit	dical	d				
89	rtifica ng ph as th		UE FEMALE.				
Division or Vital Records, P.O. Box	w requires that the death certifueen signed by the attending should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy			23d. Date of de	•
Э.	dea death ed fo	sicis	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			Month	Day Year
O .	at the by th	h.	9 Li Unknown				
Ś	es th igned be de	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given i	in Part I.			o the cause of death?
פ	equir en si ould	be			1 ☐ Ye	s 2 No 3 F	robably 4XUnknown
ပ္	law r as be 2 sh	Completed			24a. Was an	24b. Were a	utopsy findings available completion of cause of
<u>~</u>	The law)om			perform	ed? death?	
<u>ta</u>	ysician: nis certifica director, I	Be (25. Was case referred to medical examiner?	26. Place of Deat	h (Check only one)	
>	hysic his co	To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other:	4 Nursing Ho	ome 5 Reside	nce 6 □Other (Spe	ecify)
0	ding Ph J. After th funeral		27. Manner of Death 1 X Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	at	28d. Describe ho	w injury occurred	
000	endl sath. or: A the fu	atic	2 Accident investigation M 1 Yes	s 2 No			
Ĕ	r Att ter de irect irect	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Str. City or Town,	eet and Number or F , State)	lural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burors after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit						
	Hosp 4 hou Fune Fely fii	ica	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, Check only 2 Medical Examiner On the basis of examination and/or investigation, in my opin				
	the I hin 2: the I mplet	Medical	one) and planner stated. 29h. Signature and title of certifier 29c. License n	number	0.0	d Date sizes 4.4	oth Day Vocal
	vit Cor	-				d. Date signed (Mon	
_	(D)			154	ر	sure, e	107
R	(6)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Q_/(1 C#			20744
			Arastoo Yazdani M.D., 9801 Georgia Ave., Ste 3)-41, S1	.iver Spr	Tug, In	20/44
	Sta Regist		31. Date filed (Month, Day Year) 32. Registrar's Signification 33. Registrar's Signification 34. Registrar's Signification 35. Registrar's Signification 36. Registrar's Signification 37. Registrar's Signification 38. Registrar's Signification 39. Registrar's Signification 31. Registrar's Signification 32. Registrar's Signification 33. Registrar's Signification 34. Registrar's Signification 35. Registrar's Signification 36. Registrar's Signification 37. Registrar's Signification 38. Registrar's Signification 39. Registrar's Signification 39. Registrar's Signification 31. Registrar's Signification 31. Registrar's Signification 32. Registrar's Signification 33. Registrar's Signification 34. Registrar's Signification 35. Registrar's Signification 36. Registrar's Signification 37. Registrar's Signification 38. Registrar's Signification 39. Registrar's Significatio				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** :12 TUNE Catherine Ann Yaczko /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Sharpsburg 3914 Mills Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2X F Yrs 155-12-6764 May 12, 1922 New Jersey Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 3 No Director Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HSA 3914 Mills Road 21782 Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: XXWidowed 4 ☐ Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Housewife 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Josephine Murphy 2 Michael 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3912 Mills Rd. Sharpsburg, Maryland 21782 Noel M. Evanko - Daughter 20a. Method of Disposition
1 ☑ Burial 2. ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) June 16,2007 Williamsport, Maryland Greenlawn Mem. Park 21. Signature of Funeral Service OSDOPNEA FEM FEM Home, P.A. 425 S. Conococheague St. Williamsport, Maryland 23a. Part . Enter the disease, or complications that call sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on get line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) gnificant conditions contributing of eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) Certification: To 1 Tes 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Mann Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending

use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and P.O. the ۵ Division of Vital Records, this After after death. filled in by within 24 hours a To the Funeral C

Funeral

Director

28a-f show

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Iteme 23a

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"naturel",

d 2 should be filed within 7 th and Mental Hygiene.

Pages 1 and 2 s ment of Health an ant: If item 27 is jury or other traus

permit. Page Department of Important: If eny injury or once.

Pnysician /Medical

Examiner

other traumatic event, the Mudical Examiner must be notified at

Maryland

with the

filed within 72 hours after death

Baltimore, Maryland 21215-0036

1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 - Homicide crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signat re and title of certifier

CZ-5

State Registrar

completely

Medical

th, Day, Year)
JUN 15

Name and address of pe

o of death (Item 23a) (Type, Print) 32. Registrar's Signature

ed cause

State of Maryland / Department of Health and Mental Hygiene

Timonium

10f. Zip Code

16a. Decedent's Usual Occupation

1 - For State Registrar

Certificate of Death

2. Date of Death 3. Time of Death

4c. County of Death

Baltimore

Physician
/Medical
Examiner

Anna S. Antkowiak 4a. Facility Name (If not institution, give street and number) Stella Maris

1. Decedent's Name (First, Middle, Last)

June 25, 2007 4b. City, Town, or Location of Death

6:44 PM M

10d. Inside City Limits

Funeral Director

filed within 72 hours after death with the Maryland

JUNE 25, 2007 6:44 p.m. Baltimore, Maryland 21215-0036

an "natural", or Items 23a or Medical Examiner must be r

of Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the Me

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event

Physician /Medical Examiner

physician and the burial-transit

attending pl

signed by the a

certificate has been si rector, page 2 should

the funeral director

filled in by

After t

24 hours after death.

within 24 hou To the Fune completely fi

The law requires that the death certificate be executed

Hospital or Attending Physician:

ANNA ANTKOWIAK Division or Vital Records, P.O. Box 68760,

5. Social Security Number 219-16-6888 Usual Residence of Decedent

7. Age (In yrs. last birthday) 1□M 2√F 84

8. Date of Birth (Month, Day, May 30, If Under 1 Year | If Under 24 Hrs. Months Days Hours Min.

9. Birthplace (State or Foreign Mary land

r 28a-f show notified at

Director

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Baltimore

10c. City, Town or Location Timonium

1 ☐ Yes 2 No 10g. Citizen of What Country?

10e. Street and Number

2300 Dulaney Valley Rd. # W-103

Armed Force 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 21093

USA 14. Race - American Indian,

Funeral 11. Marital Status

1 Never Married 2 Married 3 Widowed 4 Divorced

12. Was Decedent Ever in U.S.

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2XXNo Specify:

Specify: White 16b. Kind of Business/Industry

Timonium, MD

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

(Give kind of work done during most of working life. DO NOT use retired) Secretary

Completed 17. Father's Name (First, Middle, Last)

John Antkowiak

18. Mother's Name (First, Middle, Maiden Surname)

Ida Nitka

19a. Informant's Name/Relationship (Type. Print)

2300 Dulaney Valley Rd. W307 Timonium, MD 21093

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

<u>Martha</u>Antkowiak (sister)

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State 06/29/2007

20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee

Dulaney Valley Mem Gras

22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 21204

23a. Part1. Ent.r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner

CONGESTIVE HEART	FAILURE
Due to (or as a consequence of):	

Due to (or as a consequence of)

Due to (or as a consequence of)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Day

Approximate Interval Between Onset and Death

IF FEMALE

Physician/Medical

Completed

Be

Certification: To

Medical

23b. Was decedent pregnant in the past 12 months?

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 2 Fetal death 4□Pregnant at time of death 9☐Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 ☐Ectopic pregnancy 5 Other (specify)

> 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an eutopsy performed? 1□ Yes 2**X** No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No

> 5 Pending investigation

JUN 2 7 2007

6 Could not be determined

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3∏ DOA 28b. Time of 28c. Injury at Work? Injury

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28d. Describe how injury occurred

26. Place of Death (Check only one)

TIMONIUM, MD 21093

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier (Check only one)

27. Manner of Death

1 X Natural

2 Accident

3 Suicide

4 ☐ Homicide

🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Indedican Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

1 Yes 2 No

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)

2300 DULANEY VALLEY RD.

State Registrar

10

DHMH 17 Rev 1/2001

ORIGINAL

10

30. Name and address of person who completed cause of death (Item 23a)
Melissa Brassell, MD Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

June 25, 2007

State 31. Date filed (Month, Day, Year)
Registrar

32. Redistrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 2. State of Maryland Department of Health and Mental Hygiene Certificate of Death

Red. No. 1 - For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 18 **Physician** 200 Oliver Anderson /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street end number) **Examiner** pital land 6 reneral TIMOTE Year If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 8. Pate of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Days Months Hours Min 1⊠M 2□F 427-46-3282 Director 76 July 10, 1930 MS Usual Residence of Decedent with the Maryland 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 1 Ves 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ber ms 23a 21218 USA 1019 Darley Avenue death v Funeral 14. Race - American Indian, items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc "natural", or iten dical Examiner filed within 72 hours after 1 M Yes 2 Mo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specif African American Completed by 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 steel worker Bethlehem Steel . c., Marylant.
.c., Marylant.
.c. mit. Pages 1 and 2 should be fileo.
Department of Health and Mental ''
Important: If Item 27 Is many Injury or other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Anderson Mary Lee Prophet P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Shawn Anderson / Daughter 2409 Elsinore Avenue #2; Baltimore, Maryland 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 05/29/2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street; Baltimore, Maryland 21217 ones 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gram Positive Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and as the burial-trans Due to (or as a consequence of): Physician/Medical as attending | for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h Was decedent pregnant Live birth 2 Fetal death 3 □Ectopic pregnancy The law requires that the death 4 Pregnant at time of death 9 Unknown Month Vear in the past 12 months? Day 5 Other (specify) ☐Yes 2☐No 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 s autopsy perform certificate 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this funeral 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: To the Hospital or Attending within 24 hours ofter death.

To the Funeral Director, After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

State Registrar

29b. Signature and title of certifier

th, Day, Year)

30. Name and address of person who complete cause of death (Item 23a) (Type, Print)

40

32. Registrar's Signature

5-0036

Baltimore, Maryland 2121

 ${\cal J}$ නිය. Division or Vital Records, P.O. Box 68760,

land

29c. License number

29d. Date signed (Month, Day, Year)

			a 191 Amand #9 ===MD =060 7/9/07 mm	partment of Health and I Fertificate of Death		giene Reg. No.	201553	
	Dhysisi	on.	1. Decedent's Name (First, Middle, Last)		2. Date of Dee Month		3. Time of Death	
	Physici /Medio			rkmaier	June	25, 2007 2:48 f		
	Examir	ner	4a. Facility Name (If not institution, give street and number) 2 Muirfield Court	4b. City, Town, or Location of Death Lutherville		4c. County of De	^{ath} imore	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdo	ay) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		rthplace (State or Foreign	
	Director		217-20-5876 1 ¹ M ² F 80 Yrs	Months Days Hours Min.	Aug. 7	1926	Maryland	
and	t w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits	
Mary	-f sho	ţō	Maryland Baltimore Luth	erville			1 ∐Yes 2X1No	
th the	or 28a e noti	Director	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What (Country?	
death with the Maryland	23a iust b		2 Muirfield Court	21093		U.S.A.		
ter de	Item:	Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No	 Was Decedent of Hispenic Origin? (Spirit Yes, specify Cuban, Mexican, Puerle 	pecify Yes or No- o Rican, etc.)	14. Hace - An Black, Wh	nerican Indian, nite, etc.	
5-0036 72 hours after	al", or Exam	þ	1 □ Never Married 2 🕅 Married 1 📉 Yes 2 □ No If Yes, Give 1944–1946	1 ☐ Yes 2 ☑ No Specify:		Specify:	White	
3-0	natur	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation ive kind of work done during most of wor e. DO NOT use retired)	king I	16b. Kind of Busines	s/Industry	
within	than the Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retired) Designer		Water & S	ewer Systems	
D D	other ent, 1	Be Co	17. Father's Name (First, Middle, Last)		ne (First, Middle,	Maiden Surname)	5 HC1	
arylan should be	Mental arked o atic eve	To B	William F. Birkmaie	rKat	herine	Weis	sing	
2 sh	is me			ailing Address (Street and Number or Ru				
-	if health and Mental hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	1	20a Method of Disposition 20b Place of Di	sposition (Name of		lle, Maryla 20c. Location - City		
Pages	ent of ht: if it y or o	3	1 X Burial 2 □ Cremation 3 □ Removal from State	y Valley 6-28		Timonium	Maryland	
DallImor permit. Pages	Department of Important: if it any injury or conce.		21. Signature (Times) Service Lidensee	I I A I GAI GEIIS	ick Tows		Home, Inc. 21204	
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.			<u> </u>	Approximate	
Ph	ysician	8 0	shock, or heart failure. List only one caur on each line. Immediate Cause (Final disease or condition	1 / 6-			Interval Between Onset and Death	
	Aedical aminer		resulting in death) Due to (or as consequence of):	-1, 1-1				
		ē	Sequentially list conditions, is any, leading to immediate	m's bisea	80		1	
cuted	nd transit	Examiner	in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	tra				
ficate be executed	physician and the burial-transit	edical Ex	Due to (or as a consequence of):					
rtificat	ng ph) as th	Medi	IF FEMALE:					
DOX path ce	aftendi for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	3 ☐ Ectopic pregnancy		23d. Date of d Month	elivery Day Year	
the de	y the s	ysic	1 □ Yes 2 □ No 9 □ Unknown 4 □ Pregnant at time of death 9 □ Unknown	5 ☐ Other (specify)				
S, T	gned b	by Pł	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?	
law requires	een sig				1 🗆 Y	es 2. No 3□	Probably 4 Unknown	
The law	te has be	Completed			24a. Was a autop perfor 1□ Yes	sy prior to	autopsy findings available o completion of cause of	
cian:	ertifica ctor, p	Be C	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only or	/ -	20110	
Physi	this cral dire	은	1			lence 6 Dother (Spow injury occurred	pecify)	
oding .	m. : After s funer	tion	1 Matural 5 Pending (Month, Day Year) Injul 2 □ Accident investigation		20d. Describe II	ow injury occurred		
or Atten	Director Director in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (S City or Tow	treet and Number or n, State)	Rural Route Number,	
Hospital	winin 24 hours are locarn. To the Funeral Director: After this certificate has been signed by the aftending completely filled in by the funeral director, page 2 should be detached for use as	edical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, d 2 Medicel Examiner: On the basis of examination and/o	eath occurred at the time, date and place r investigation, in my opinion, death occu	, and due to the o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)	
o the	romple	Med	29b. Signature and title of certifier	29c. License number	2	29d. Date signed (Mo	nth Day, Year)	
			John W. TSower mg	D20649	b	6/25	12007	
	let 1		30. Name and address of person who completed cause of death (Item 23a) (Tyludhan Bowie, M.D. 6701 North Cha	rles Street Ralti	more, Ma	aryland 21	204	
H	Sta Registr		31. Date filed (Month, Day, Year) JUN 2 7 2007 32. Registrar's Signature	bade				

	_ POF	partment of Health and Mental ertificate of Death	Hygiene 007 20664
	Decedent's Name (First, Middle, Last)	2. Date Mont	of Death 3. Time of Death
Physician /Medical	Doris Elaine Burton	Ju	NE 22 2007 3.43 FM
Examiner	4a. Facility Name (If not institution give street and number)	4b. City, Town, or Location of Death	4c. County of Death
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	av) If Under 1 Year If Under 24 HVs. 8, Date	of Birth 9. Birthplace (State or Foreign
Funeral Director	5. Social Security Number 6. Sex 1 M 2 X F 81	Months Days Hours Min. (Mon	of Birth th, Day, Year) 9. Birthplace (State or Foreign Country) Maryland
	Usual Residence of Decedent		
nylan how	10a. State 10b. County 10c. City, Town or	r Location	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the Mar tor 28a-fel be notified Director	MD Harford Fallsto		10g. Citizen of What Country?
death with the Maryland me 23s or 28s-f show rmust be notified at	10e. Street and Number	10f. Zip Code	
South of the country	613 Mountain Road 11. Marital Status 12. Was Decedent Ever in U.S.	21047 13. Was Decedent of Hispanic Origin? (Specify Yes	U.S.A. or No- 14. Race - American Indian,
. 6 £ 6 J.∋	Armed Forces? 1 ★ Never Married 2 Marned 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ Yes 2 ☒ No Specify:	Black, White, etc. Specify: 571 1 5 5
27.7.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.	3 Widowed 4 Divorced If Yes, Give Year or Dates:		wnite
21215-0036 ed within 72 hours after death with the Marylan yaplen. yaplene. t, the Maritical Example must be notified at Completed by Funeral Director	(Specify only highest grade completed) (G	ecedent's Usual Occupation five kind of work done during most of working fe. DO NOT use retired)	16b. Kind of Business/Industry
withing Market	Elementary/Secondary (0-12) College (1-4or 5+)	omemaker	Own Home
nd 2 be filed tal Hygin d other event, I	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, M	
Maryland 21215-0036 Maryland 21215-0036 **A 2 should be filed within 72 hours alf tills and Marcal Hygiens, or 77 is marked other than "natural; or 1 traumatic event, the Marked Exert To Be Completed by F	Clifton Arnold Burton	Helen Franc	
Taryla Taryla 2 should and Men 1 marks aumatic To		ailing Address (Street and Number or Rural Route	- 1
	Helen Sharon Arnold 61	13 Mountain Road - Falls spesition (Name of Date	ston, Maryland 21047
Butimore, sernit. Pages 1a pages 1a mportant. It them my rightry or other bids.	1 M Burial 2 ☐ Cremation 3 ☐ Removal from State	crematory or other place)	
Baltim Baltim Permit. Pa Departmen Important eny injury	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	Memorial Gdns.06/27/20	Lassahn Funeral Home, P.A.
Balt Balt Departit. Departit Import Import International Particles	E. G. Lassahn	11750 Belair Road - Kir	ngsville, Maryland 21087
	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respira	atory arrest, Approximate Interval Between Onset and Death
Physician	Immediate Cause (Final disease or condition resulting in death) a	e Heart Failure	3.100.11.10
/Medical Examiner			
	b. Due to (or as a construe of any, leading to immediate	Man, an	y ear
b, cxecuted and and ial-transit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
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8760, <cate and="" be="" burial-transit="" dloal="" examír<="" executed="" physician="" th="" the=""><td>d</td><td></td><td></td></cate>	d		
x 68 entific ling pl	IF FEMALE:		201 200 1100
is, P.O. Box 6 es that the death certific gened by the attending p be detached for use as by Physician/Mee	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
O. the de ched ched	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	Gillot (specify)	
S, P. es that es that gened by be deta	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I. 236	a. Did tobacco use contribute to the cause of death?
cords, vequires been signishould be	- Pwarfism, capabrovas	No accident	1 Yes 2 (XNo 3 Probably 4 Unknown
		24a	a. Was an 24b. Were autopsy findings available prior to completion of cause of
The The page		10	performed? death? Yes 2万No 1 ☐ Yes 2 ☐ No
Vital Ficien: The certificate sector, pag	25. Was case referred to medical	26. Place of Death (Check	conly one)
Physical this call direction and direction a	1		☐ Residence 6 ☐ Other (Specify) scribe how injury occurred
ding P. After funer funer	27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigation 2 □ Accident		
rision Attendia r death. octor: A y the fu	2 Accident investigation 3 Suicide 6 Could not be determined deter	n, street, factory, office 28f. Loc	ation (Street and Number or Rural Route Number,
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Division of Vital Recard to the Hospital or Attending Physician: The law within 24 hours etter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp		death occurred at the time, date and place, and due or investigation, in my opinion, death occurred at the	to the cause(s) and manner as stated. e time, date and place, and due to the cause(s)
ro the vithin. To the comple	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	De a Munn	027975	6/24/02
3	30. Name and address of person who completed cause of death (Item 23a) (Ty	ype, Print)	4
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			For State		Sta	te of Ma	arylan		artmen <i>rtificat</i>				1ental F	-				
-			Registrar 1. Decedent's Name	(First Middle	Last)			06	lilloat	e or i	Dealii		2. Date of	Reg. Death	No.	UI	3. Time o	of Death
4	Physici		Phy11:		, 2401)	Bra	un						Month June	24.	Day 2007	Year	2140) M
	/Medic		4a. Facility Name (If		give street a	nd number)			4b. City,	Town, or	r Location	of Death			4c. County	of Death		
				Chesar	eake					Air					Ha	rfor		
	Funeral		5. Social Security No		6. Sex 1 ☐ M 2[last birthday, Yrs.	If Unde Months	r 1 Year Days	If Under Hours	r 24 Hrs. Min.	8. Date of (Month,	Day, Ye	ear)	Coui		or Foreign
	Director		070-34-1 Usual Residence of			X	64	113.					Jan 8	, 19	943	New	York	
	/land low at		10a. State	10b. County			10c. City	, Town or L	ocation								10d. Inside (City Limits
	a-f sh ified	cto	MD	Harfor	d		Ве	el Air										s 2 No
	ith the or 28	Director	10e. Street and Nur						10f. Zip						Citizen of \	What Cou	ntry?	
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0	after de or items miner n	Funeral	11. Marital Status1 □ Never Marri	ed 21X Marri	ed 1	s Decedent ! ned Forces?]Yes 2 🛣		5. 13.			an, Mexica	an, Puerto	ecify Yes or Rican, etc.)	NO-	Blac	ck, White,	etc.	
26	urs af ai", or Exam	क्	3 ☐ Widowed		I If Y	es, Give ar or Dates:			1 🗆 Yes	2XNo	Specify	/ :			Specify	Whi	te	
~0	72 ho natur lical I	Completed	(Spec	15. Decedent	's Education	leted)		I (Give	edent's Usu kind of wo	ork done	durina mo	st of work	ting	161	b. Kind of B	usiness/In	dustry	
702	ne. han "	ğ.	Elementary/Seco		1	lege (1-4or 5	5+)		DO NOT u	ise retired	d) -				Nurser	37		
12	iled w Hygie ther t		12 17. Father's Name (First, Middle.	Last)			Mana	ger		18. Moth	ner's Nam	e (First, Mic					
a J	should be ind Mental smarked o	To Be	Frank Me	•	•						Ann	a Mai	cone					
arylahd 212	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	-	19a. Informant's Na	ame/Relationsl	nip (Type. Prii	nt)		19b. Mail	ing Addres	s (Street	and Numi	ber or Rui	ral Route Nu	ımber, C	ity or Town,	State, Zij	o Code)	
T.	and 2 ealth a n 27 is	1	Dennis F		ı – Hus	band					le D		nit N					
(K) 8	ges 1 i of He if iten		20a. Method of Disp 1 Durial 2		3 □Remova	I from State	C	Place of Disp cemetery, cre	ematory or	other plac			Date		c. Location	•		
Ei 3	t. Pag tment tant: jury		4 ☐ Donation				Cal	lverto					-29-07		Calver			
Bal	permit. Departr importa any inji		21. Signature of Fu	the V	July 1	20	2	4	z. Name a				Lan & Ave.					L Home 1768
			23a. Part1. Enter the	he disease, or art failure. List	complications only one caus	that caused se on each li	d the deatline.	h. Do not er	iter the mo	de of dyir	ng, such a	s cardiac	or respirato	ry arrest	,		Approxim Interval B	ate etween
	Physician		Immediate Cause (disease o conditio	(Final n	a. 'I	nela	Such	10	Lyn	4	CA	Vce					Onset and	
-	/Medical Examiner		resulting in death)			oue to (or as	a conseq	uence of):		1								0
		-e	Sequentially list co	nditions,	b	Due to (or as	a conseq	uence of):				_						
QV	uted d ansit	Examiner	Sequentially list confirmed in the confirmed in the cause. Enter Under Cause (Disease or that initiated events	erlying injury														
do	be executed ician and burial-transit	Exa	resulting in death) I	Ĺast	Ç	Due to (or as	a conseq	uence of):										
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W. X	certifica ding pl	Mec	IF FEMALE:		230 If v	es, outcome	o of pregns	ancy							004 D			
74 Bo	ath itter	Physician/Me	23b. Was deceden in the past 12	months?	10	Live birth Pregnant a	2 Feta	al death 3	□Ectopic p		у				1	ite of deliv	Day	Year
<i>'</i> Qo'	0 00	ysi	1 □ Yes 124 9 □ Unknown	No		Unknown				,, , _								
Sol.	requires that the een signed by the rould be detache	y P	Part II. Other signif	ficant condition	ons contribution	ng to death b	out not res	ulting in the	underlying	cause giv	en in Par	t I.	23e. [Oid tobac	cco use con	tribute to	the cause o	f death?
Z g	w requires that been signed be should be det	Completed by						_					ئ	Yes	2 □ No	3 ☐ Pro	bably 4	Unknown
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E B	: The l	Con											1 7	es 20	No	death? 1 ☐ Yes	2 ☐ No	
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J (noi	Attending Pr r death. ector: After they they they they the funeral	tion	1 Natural 2 Accident	5 ☐ Pendin investi	g gation	(Month, Da	ay Year)	Injury	М		rk?]Yes 2[□No						
Nisiv Sisiv	r Attender death	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ		. Place of inj building, e	jury - At he	ome, farm, s fy)	treet, facto	ry, office			28f. Locati City of	on (Stree	et and Num State)	ber or Ru	ral Route No	ımber,
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Z	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the it	Medical	29a. Certifier (Check only one)	2 Medical	ng Physician: Examiner: O ar	To the best in the basis o nd manner st	of examina	owledge, dea ation and/or	ath occurre investigation	d at the to on, in my	ime, date opinion, d	and place leath occu	e, and due to irred at the t	the cau ime, date	se(s) and m e and place	anner as , and due	stated. to the cause	e(s)
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			16	2	Mrk	}				P 04	49	YY		Ju	me	32	1, 30	07
	5		30. Name and add	ress of person	who complete	ed cause of		0	e, Print)	m 1	HO	- }	tr.	h	1	11	Λ	12
	~ C1		31. Date filed (Mor	th, Day, Year)	WAL	32. Regist	rar's Signa		ササ	1467	140	2/10	71 7	1466	1 09	Time	ore 11	Mayala
	St Regist	ate rar	(1710)	JUN 2 8	2007	Ser.		J. 16%	THE L									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 20655 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Mae Month Dav Blue Year 49 AM **Physician** elori JUNE 200 25 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner Huspital olumbia Howard County General Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2 □ F 175-26-9110 Yrs 74 22, 1932 Director Aug. Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f sh other traumatic event, the Medical Examiner must be notified 1 ☐ Yes 2 ☐ No Director MD Howard Columbia 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 7651 Woodpark Lane Apt. 104 21046 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: ò 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Williams Jirlee Branch 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ramona Mack 12551 Canary Lane King George, VA 22485 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot once. Burial 2 Cremation 3 Removal from State 6 - 30 - 07Bethlehem Memorial Pk 4 ☐ Donation 5 ☐ Other (Specify) Bethlehem, 22. Name and Address of Facility Cedell Brooks Funeral Home, f Funeral Service Licensee Inc. 25662 A.P. Hill Blvd Port Royal, VA and the hier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Diabetes Immediate Cause (Final years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to influentiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical P N IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death NA 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hupertension Essential 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ★ No 24a. Was an page 2 s 1☐ Yes or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မှ this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director; A 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29h Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

H

1) 56531

June 25, 200

ste 301, Columbia, MD 21045

M. D.

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harry Li, 8600 Snowden River

31. Date filed (Month, Day, Year)

Anr	ia biaiozynsi		I- For State	r Maryland / Depa Ce	artment of Healtr rtificate of Death	and Mental H	-	No. 201	7 2065
	Physici		Registrar 1. Decedent's Name (First, Middle,Last)				Reg. 2. Date of Death		3. Time of Death
Ме	dical Exami		Anna Frances Bi	alozynski			Month E June 21, 20	Day Year 07	0738 hrs
			4a. Facility Name (if not institution, give	street and number)		wn, or Location of Death	1	4c. County of Dea	th
			Good Samaritan Hospital	7. Age (In yrs.	Baltimo		Dete of Birth	(MM/DD/YYYY) g. B	inthology (State or
	Funeral Director		5. Social Security Number 6. Sex		Months	Days Hours Mir	_	Fore	eign
	Birostor	I	218-46-8051 1 1 NUSUS Residence of Decedent	л 2 <u>X</u> F	58 Yrs.		19-13-1	940	country) MD
	a service and a service and	to the significance	10a. State 10b. County	10c. City	, Town or Location				10d. Inside City Limits
7	nd show	١	MD Baltimo	re Co. Mid	dle River				1 Yes 2 X No
1	taryla	ect	10e. Street and Number	. Citizen of What Co	untry?				
5	the Na or	늅	1018 Susquehann	a Avenue	212	20		USA	
	h with	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?		of Hispanic Origin? (S Cuban, Mexican, Puerto			erican Indian, Black,
	r deat or ite	Ε̈́	1 Never Married 2 Married	1 Yes 2X No			, modify otoly		
	rs afte ural",	þ	Widowed 4 Divorced 1 Decedent's Education (Specify only)	or Dates:	1 Yes 2 X		work done	Specify: W	hite s/industry
	2 hou "nat	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		ng life. DO NOT use ret			
	036 Ithin 7 ne. r than	nple	10	N/A	Reception	ist		Medical	Office
	5-0 led wi Hygie other		17. Father's Name (First, Middle, Last)	11/.43	- Reception	18.Mother's Nam	e (First, Middle, Ma		
	121 J be fi ental arked vent,	Be	Andrew Urbanows	ki		Anna Sn	nith		
	D 2 should and M 7 is m	L	19a. Informant's Name/Relationship (Type						te, Zip Code) 21220
	and 2 ealth 2 em 2 traum		Robert Bialozyn 20a. Method of Disposition	<u>ski-Husband</u> 120b.	I II 0 I 8 SUSQ Place of Disposition (Name	uehanna <i>E</i> of cemetery.	Avenue N	11 dd Le R 20c. Location - City	1 Ver , MD
	Ore ges 1: t of H : If it		1 XBurial 2 Cremation 3	Removal from State	crematory or other place)			·	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	1 1	4 Donation 5 Other Specify: 21 Signature of Funeral Service License	i Ce	edar Hill C	ddress of Facility -	5-25-07 ₁	<u>Glen Bu</u>	rnie, MD al Home,PA
	Ba Depa Imp								, MD 21222
	Physician		3 Part I. Enter the disease, or complic						Approximate Interval
	/Medical		failure. List only one cause on eac Immediate Cause (Final disease a.	n une. Terminal renal d	isease complica	ting atherosc	lerotic car	diovascular	Between Onset and Death
	Examiner		or condition resulting in death)	ue to (or as a consequence o	of): disease				
		<u>.</u>	Sequentially list conditions, if any, leading to immediate D	ue to (or as a consequence	Sf):				-
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	de to (or as a consequence of	51).	5.9			
	ed sit	ха	events resulting in death) Last	ue to (or as a consequence o	of):				
1	xecuted n and l - transit		d.	AMENDED					-
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	Sox 68761 death certificate te attending phy 1 for use as the b	N/N	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	3 Ectopic pregn	ancy	Month	ery Day Year
	ox 6 ath ce attend or use	sici	1 Yes 2 No 9 ✓ Unknown	4 Pregnant at time of d	eath 5 Other (Specia	fy)			
	the de	Physician/I	Part II. Other significant conditions	g Unknown	resulting in the underlying o	rause niven in Part I	23e Did tob	acco use contribute	to the cause of death?
	cords, P.O. B. law requires that the de has been signed by the 2 should be detached !	by	Scleroderma, hydr	•	resulting in the underlying t	duse given in real r.	1 Yes		robably 4 🗸 Unknown
	ds, equire een sig	ed	<u> </u>	оперия тель		•	24a. Was ar		autopsy findings available
	cords law requi	Completed					autops; perform	ned? death	personal control of the control of t
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Fineral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	ပ်	25. Was case referred to medical		26	S.Place of Death (Check	1 Yes 2	No 1 🗸	Yes 2 No
	Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Finneral Director: After this certific completely filled in by the funeral director,	o Be	examiner?	espital: 1 Inpatient 2	ER/Outpatient 3 DC	IOthan :=		tesidence 6 🗸 Oth	ner: Scene
9	of V g Phy fter th	Ë	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day,Year)		Bc. Injury at Work?		ow injury occurred	
	on endinath.	tio	1 X Natural 5 Pending			1 Yes 2 No			
	ViSi or Att Rer de Directe in by	ifica	2 Accident Investigation 3 Suicide 6 Could not be	28e Place of Injuny . At h	nome, farm, street, factory,	office building, etc.			Rural Route Number, City
	Dipital of ours all filled	Certification:	4 Homicide determined	(Specify)			or Town, Sta	ite)	
	e Hos 124 ho e Fiin letely	cal (n: To the best of my knowled					
	To th within To th	Medical		On the basis of examination and manner stated.			at the time, date a		
		2	29b. Signature and title of certifier		ı	O.C.M.E.		29d. Date signed (A June 22, 2007	iontn, Day, Year)
			Vav.			O.O.IVI.L.			
-	- 1		 Name and address of person who co Ana Rubio MD. Assistant 	empleted cause of death (Iter t Medical Examiner	ո 23a) - 111 Penn Street, Ba	altimore, MD 2120)1		
	S	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signal					
	Regis		JUN 2 7 20	107 Ken	K A. K.				
	DHMH 17 Rev 1/2	2001		1	ORIGINAL			OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Burges5 verh Sunc 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Baltimore 10 pllins tospital If Under 1 Year | If Under 24 Hrs. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 □ M 2 □ 212-56-7299 Director 9-6-1952 Md. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show must be notified at Director 1X Yes 2 □ No Baltimore Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or USA 21213 3713 Belair Rd. Apt. 2 Funeral Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 10 1 ☐ Yes 2 ☐ No Specify. þ Specify: Black 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) the Disabled NA llth grade nt of Health and Mental Hygie If item 27 is marked other or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thelma Burgess Manning ပ္ Leroy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3525 Pelman St., Baltimore, Md. Danielle Ellison Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or otl once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-23-07 Druidridge Cem. Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East la 1101 E. North Ave., Baltimore, Md. 21202 on 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consquence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Exami attending physician and for use as the burial-tran Due to (or as a consequence of): by Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached 1 I Yes 2 □ No 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy certificate Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 ☐ Yes Inpatient ۲ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 (Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: s after death.

I Director; After this
of in by the funeral d within 24 hours aft

To the Funeral Di

completely filled in

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Ootherine Comprell

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Check only one)

Catherine Compbell Johns Hopkins Hospital Goo North wolfest The

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Res-bol

29d. Date signed (Month, Day, Year)

June 25, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year 2000 20 /Medical 4c. County of Death 4a. Facility Name (If ng institution, give street and number Examiner NA 10/1 Security Numbe Sex Age (In vrs. ast birthday) If Under Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral №** M 2□ F Days Year) Months Director 217-84-6155 1-17-61 Md. 46 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Item 27 Is marked other than "natural", or items 23a or 28a-f sho≀ other traumatic event, the Medical Examlner must be notified at 1X Yes 2 No Director Baltimore NA Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21213 608 Potomac Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify. Black Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Various Laborer 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be fi and Mental H Be Hill Mae Maggie Boomer ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 Is any injury or other trau Pages 1 and 2 4712 Chatford Ave., Baltimore, Md. Deborah A. Johnson Boomer Wife altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 6-26-07 Greenmount Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F.H. East 21202 1101 E. North Ave., BALTIMORE, Md. 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician UR. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of). Examine death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. I been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 V 0 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s autopsy certificate 2 funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA မှ 1 npatient 27. Manner of D. ath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After Injury 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier To the cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Stat

State 31. Date filed (Month, Day, Year)
Registrar

Degistrar's Signature

MEDICAL

DHMH 17 Rev 1/2001

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Baltimore

2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🗀 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Agnes T. Buzgierski 2007 7:56 June a. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Gilchrist Center Towson 8. Date of Birth (Month, Day, Year)
Jan. 12, 1 If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Days Months Hours 1 □ M 2 🕅 F 92 Maryland 213-07-0005 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☑ No Maryland Baltimore Edgemere 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6502 North Point Road 21219 United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 21 No If Yes, Give 1 ☐ Yes 2 ☐ No Specify. Specify: 3 □ Widowed 4 □ Divorced Year or Dates: White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 years Self_Employed Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosalie Dobrzycka Andrew Tomczewski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John Buzgierski (Son) 6508 North Point Road Baltimore, Maryland 21219
20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) cred Heart of Jesus 6/25/2007 Dundalk, Maryland 22. Name and Address of Facility 21. Signature eral Service Duda-Ruck Funeral Home of Dundalk, Inc. Part. Enter the dise file, or complications that caused the deal. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Dundalk Marvland 21222

Approximate interval Between Onset and Death immediate Cause (Final Due to (or as a consequence of): months disease or condition resulting in death) Sequentially list conditions, any parting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

29d. Date signed (Month, Day, Year)

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Be မ 10a. State

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examiner physician and s the burlal-transit The law requires that the death certificate be executed by Physician/Medical as signed by the attending I be detached for use as Completed

has certificate within 24 hours after deau...

To the Funeral Director: After this certifica

Be ို

Certification:

Medical

29a, Certifier

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician:

IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part i.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unkno
		24a. Was an autopsy performed? death? 1 Yes 2 No
25. Was case referred to medical	26. Place of Death (C	Check only one)
examiner? 1 ☐ Yes 2 ☐ No	Hospital: Other:	5 ☐ Residence 6 COther (Specify) (10)SO(C
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury Work? on M 1 ☐ Yes 2 ☐ No	f. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Ligary 31. Date filed (Month, Day, Year) JUN 2 7 2007

30. Name and address

29b. Signature and title of pertifier

of person who completed 32. Registrar's Signature

completed cause of death (item 23a) (Type, Print)

Vellarles ST 101

🗫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:50 p.M /Medical Kathleen Mary Bowen June 21 2007 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Ider 1 Year | If Under 24 Hrs. Ins | Days | Hours | Min. Baltimore 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Director 215-54-1299 59 Feb. 4, 1948 Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a, State 10c. City. Town or Location 10b County 10d. Inside City Limits iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3339 Wallford Drive 21222 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Completed by Specify: 3 ☑ Widowed 4 ☐ Divorced "natural", Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Campus Minister Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis J. McLhinney ဥ Catherine G. Goldsborough 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Charles (Niece) Joy Court Bear, Delaware 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 Surial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 6/25/2007 21. Signature of Funeral Society bice see 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Part1. Enter the disease, or complications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ENDOMETRIAL CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician ar Due to (or as a consequence of): Physician/Medical ast attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 X No Day signed by the a 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy page performe certificate 2X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Nother (Specify)} \) HOSPICE 1 Inpatient ို 1 ☐ Yes 2 📉 No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760. BOWEN KATHLEEN

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours at To the Funeral C completely filled i

10

State Registrar

Medical

TARIQ MAHMOOD

29d. Date signed (Month, Day, Year) 6/21/07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. TIMONIUM, MD 21093

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 18:17 PM Bollack UNE 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Bayview Medical Center N/A Kins Year If Under 24 Hrs. 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🖵 F 213-28-8255 Director 12,1930 Nov. Maryland Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Show r 28a-f sh 1 ☐ Yes 217 No Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code r items 23a or 2 Pages 1 and 2 should be filed within 72 hours after death with in nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or items 23a or? 1249 South 48th Street Completed by Funeral 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian iral", or item Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. 3 Widowed 4 Divorced White or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Toll Facility 12 Years Toll Collector 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Severn 2 Lillian Whitty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. Edward Bollack 1249 South 48th Street (Husband) Dundalk, MD 21222 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 4 ☐ Donation 』 5 ☐ Other (Specify) 6/26/2007 Glen Burnie, MD 21. Signatur of uneral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final **Physician** SECSIS days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner NEUMONI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician The law requires that the death certificate be Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 5 ☐ Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 s autopsy 2 □ No 212 No 1 ☐ Yes or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[9 No 1 ☐ Yes 1 npatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation (Month, Day Year) Injury 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: / completely filled in by the fi 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the ! 29c. License number 29b. Signature and title of certifle? 29d. Date signed (Month, Day, Year)

State Registrar

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31. Date filed (Month, Day, Year)
JUN 2 7 20

azmin

MIN MOVOLES 4940 ay, Year) 32. Registrar's Signature

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Fastern Avenue, Baltimore, MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For 2. Date of Death [□]2007

3. Time of Death

12:00 A M

June 25,

4c. County of Death

Baltimore

			1 - State Registrar					Cer	tifica	te of	Death)
			1. Decedent's Name (First, Midd	le, Last))							
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	/Medio		4a. Facility Name (If not institution			mber)			4b. City	, Town, o	r Location	of Death
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			5. Social Security Number	6. Sex	ĸ	7. Age	e (In vrs. la	ast birthday)		r 1 Year		r 24 Hrs.
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, , Š	ural"	d by	3 ☐ Widowed 4 ☐ Divorce	1	Year or D	Dates:						
5.0	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medikal Examiner must be notified at	Completed	15. Decede (Specify only high	nt's Edu est grad	cation e completed)		1	16a. Deced (Give	ent's Usu k <i>ind of w</i> e	ual Occup ork done	ation <i>during mo</i> d)	st of wor
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7,5	should be and Mental marked o		19a. Informant's Name/Relation	ship (Ty	pe. Print)			19b. Mailin	g Addres	s (Street	and Numb	er or Ru
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120	Pages nent of h		1X Burial 2 ☐ Cremation			State		emetery, cier	•		ce)	06/2
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CARROLL, CARCLEE Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Licens	ee Will:	iam	G. D	au "	. Name a	ind Addre	ss of Faci	"'y Ruc
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		ē	Sequentially list conditions, if any, leading to immediate	,	Due to	(or as a	a consequ	ence of):				
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<u>α</u>	hat the	Completed by Physician	Part II. Other significant condit	ions co	ntributing to c	leath hu	ut not resu	Iting in the ur	ıderlyina	cause div	en in Part	1.
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o	th: :: Aft	Ę.	1 ☐Natural 5 ☐ Pendi 2 ☐ Accident invest	ng igation	(Mol	nth, Day	rear)	Injury	М		rk? Yes 2.[]No
Division or Vital Records,	Atter dea ctor	fica	3 Suicide 6 Could	_	28e. Plac	e of inju	ıry - At hoi	me, farm, str	eet, facto	ry, office		
O.	after Dire	Certification:	4 ☐ Homicide determ		build	ling, etc	c. (Specify	7				
_	 Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and etely filled in by the funeral director, page 2 should be detached for use as the burial-transit 	2	29a. Certifier 1- Certify	ing Phy	sician: To th	e best o	of my knov	vledge, death	occurre	d at the ti	me, date a	and place
	24 h Fui etely	dical			Iner: On the I	basis of	f examinat					

24 Hrs. 8. Date of Birth Min. (Month, Day, Year) Feb 13, 1941 Birthplace (State or Foreign Country). New York 10d. Inside City Limits 1 ☐ Yes 2 X No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, rigin? (Specify Yes or No-an, Puerto Rican, etc.) Black, White, etc. Specify: White 16b. Kind of Business/Industry st of working Medical er's Name (First, Middle, Maiden Surname) Smith F. largaret per or Rural Route Number, City or Town, State, Zip Code) Phoenix, MD 21131 20c. Location - City or Town, State 06/29/07 Timonium, MD ^{ity}Ruck Towson Funeral Home, Inc. <u>, Towson, MD</u> 21204 Approximate Interval Between Onset and Death s cardiac or respiratory arrest, CeR 76616 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2☐ No e of Death (Check only one) lursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred ΠNο 28f. Location (Street and Number or Rural Route Number, City or Town, State) and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Li 25, 200/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Much Ca ST. Beilt ind 20 205 - 3111C 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar DHMH 17 Rev 1/2001 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Donr	na Marie	Citr		- For State	Maryland /	Department of Certificate of		Mental Hy	giene Reg	20	07 2067
Registrar Physician/ 1. Decedent's Name (First, Middle,Last)						2	2. Date of Death	Day Year	3. Time of Death		
Med	lical Exa	mir		Donna Marie Ciciano						07	1453 hrs
1				 Facility Name (if not institution, give str Johns Hopkins Bayview Med 		ŀ	4b. City, Town, or L Baltimore	ocation of Death		4c. County of D	Jeath
	Funer	·0		5. Social Security Number 6. Sex		In yrs. last birthday)	If Under 1 Year	If Under 24Hrs.	8. Date of Birth	(MM/DD/YYYY) 9	J. Birthplace (State or
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	any		ı	10a. State 10b. County	10	oc. City, Town or Locat	on				10d. Inside City Limits
***	and show	nce.	5	MD N/	A	Baltimor	9				1 X Yes 2 No
2	Maryl 28a-f	d at o	Director	I0e. Street and Number			10f. Zip Code		10g	. Citizen of What	Country?
017	th the	otifie		629 S. Grundy Şt	reet		21224			USA	Plant.
	death with the Maryland or items 23a or 28a-f show	st be	Funeral	11. Marital Status 1 Never Married 2 Married	2. Was Decedent E Armed Forces?	If Y	s Decedent of Hisp es, specify Cuban,			14. Race - A White, e	American Indian, Black, etc.
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	15-(filed v I Hygi	t, the	ပ	17. Father's Name (First, Middle, Last)				8.Mother's Name (
	212 uld be Menta marke	even	o Be	Joseph Anthony (19a. Informant's Name/Relationship (Type	<u>Sitrano </u> ,Print)	19b. Mailin	g Address (Street	Doroth and Number or Ru	v Stieb ural Route Numb	reth er, City or Town, !	State, Zip Code)
	AD 2 show and and 27 is	matic		Michael Bowman-S	on	7261	Bridge	wood Dr	. Balt	imore,	MD 21224
	e, P I and Health item	r trau		20a. Method of Disposition		20b. Place of Dispos		netery,	Date	20c. Location - Ci	ty or Town, State
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	Baltimore, MD 21215-0036 pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho	nry o	- 1	21. Signature of European Service Licenses		22.1	lame and Address	of Facility Kac:	zorows	ki Fune	ral Home,PA
				Mill M		П 20) Dunda	alk Ave	. Ralt	imore.	MD 21222
	Physicia /Medic]	3a. Part I. Enter the disease, or complicate failure. List only one cause on each	ine.				respiratory arres	it, Shock, or near	Between Onset and Death
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			iner	if any, leading to immediate Due cause. Enter Underlying Cause	to (or as a conseq	uence of):					
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	68760 certificate b nding physi	the b	sician/Me	F FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome	e of pregnancy	etal death 3	Ectopic pregnar	ncv	23d. Date of de Month	elivery Day Year
	x 68 h certi tendin	use a:	icia		Pregnant at ti	mo of dooth	ther (Specify)		,		
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	of Vital Records, ag Physician: The law requir offer this certificate has been s	uneral director, page 2 should be detached for use as the burial - transit	Be	25. Was case referred to medical examiner?	oital: 1 Inpatien	t 2 🗸 ER/Outpatien		of Death (Check o		Residence 6	Other:
	of V s Phys ter thi	eral di	유	1 Y Yes 2 No 27. Manner of Death	28a. Date of Injury	/ 28b. Time of				ow injury occurred	
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	Division tal or Attendin rs after death.	n by t	ertification:	2 Accident Investigation 3 Suicide 6 X Could not be		ry - At home, farm, stre		uilding, etc.	28f. Location (St	reet and Number	or Rural Route Number, City
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	Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys	completely		29a. Certifier 1 Certifying Physician: one) 2 Medical Examiner: One	To the best of my	knowledge, death occu	rred at the time, da	ite and place, and	due to the cause	(s) and manner as	s stated.
	To th withi To th	comp	Medical	29b. Signature and title of certifier	d manner stated.		29c, License		110 11110 11110 1		(Month, Day, Year)
4			2	29b. Signature and title of Certifier	\ //L		O.C.N			June 25, 200	
			ļ	30. Name and address of person who coo	inleted cause of do	ath (Item 23a)					
					int Medical Exa		nn Street, Balti	imore, MD 212	201		
				31. Date filed (Month; Day, Year)	32. Redistrar's	N A	mele				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 17, 2007 10:35A M June Lucy Ellen Coward /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 □ M 2 🔀 F June 23, 1931 75 Missouri Director 478-34-1505 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County sa or 28a-f show t be notified at 1y Yes 2 □ No Director Anne Arundel Odenton Maryland| 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a 21113 553 Rita Drive United States Funeral 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items 11. Marital Status Black, White, etc. 11X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married 1 ☐ Yes 2 🔀 No Specify: 2 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) 7 is marked other than traumatic event, the M Analyst Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Pages 1 and 2 should be f nent of Health and Mental I int; If item 27 is marked ol Godsey ဥ Ralph Bowling Mildred Ann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Odenton, Maryland 21113 553 Rita Drive Thomas P. Coward/ spouse If item 27 or other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State ò Department o Important: If any injury or 6/19/2007 Odenton, Maryland 4 □ Donation 5 □ Other (Specify) Arundel Crematory: 22 Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 411 Annapolis Road Odenton, Maryland 21113 21. Signature of Funeral Service Licens 1411 Annapolis Road ianital Momas 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Iscemic Bowel Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed Enterocutaneous Fistula physician and s the burial-trans Due to (or as a consequence of) Physician/Medical as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year ģ in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 1 ☐ Yes 2 💢 No certificate 2X No Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No 1X Inpatient 2 ER/Outpatient 3 DOA 2 this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. he Funeral Director; After t Certification: After (Month, Day Year) 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2. and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

Maryland 21215-0036

Baltimore,

Box 68760,

P.O.

Records,

Division or Vital

31. Date filed (Month, Day, Year) JUN 2 7 2007 Registrar



30. Name and address Train on who completed cause of death (Item 23a) (Type, Print)

D0055703

Riverdale, Maryland 20737

June 17, 2007

Physician Medical Examiner A Facility Name (Free, Mode, Last) Foundation of the Physician Medical Examiner A Facility Name (Free, Mode, Last) Foundation of the Physician Medical Examiner A Facility Name (Free, Mode, Last) A Facility Name (F	nent of Health and Mental Hygiene cate of Death	FOR	7 20676
A Facility Name of Food Methodology or James and remember? Morningside House of Friendship Funeral Director Funeral Director June Response of Code Security Water of December 138 16 2085 138 16 2085 June Response of December 138 18 18 18 18 18 18 18 18 18 18 18 18 18	2. Date of Death Month Day	Decedent's Name (First, Middle, Last)	
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Trys icrian Medical Examiner	Gonce Tuneral Der	21. Signature of Funera Pervis Ticensee 22. Nam	
Medical Examiner Part	e mode of dying, such as cardiac or respiratory arrest,	shock, or heart failure. List only one cause on vach line.	Approximate Interval Between Onset and Death
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2009 My m 12009 06/25/6-	curred at the time, date and place, and due to the cause(s) and mai gation, in my opinion, death occurred at the time, date and place, a	29a. Certifier (Check only (Ch	nanner as stated. e, and due to the cause(s)
30. Name and address of person who completed dauge of death (Item 23a) (Type, Print)	29c. License number 29d. Date signed	29b. Signature and the of centition	1ed (Month, Day, Year)
The state of the s	ielvan flak Drug Rlen	30. Name and address of person who completed dayse of death (Item 23a) (Type, Print)	Burnie and 200
State Registrar 31. Date filed (Month) Pay Year) 2007 32. Registrar's Signature		State JUNY (ZUU / Flancing of Application	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend #31, perDVR, G868, 6/27/07 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** CHARNE SARAH w 200 /Medical 4a. Facility Name (If not institution, give street and number City, Town, or Location of Death ounty of Death **Examiner** Bal 8 Ran SIC to If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F 820-01-2758 Director 04/14/1911 ICELAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-1 shov any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Funeral Director MD N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2723 CYLBURN AVENUE 21215 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □ Yes 2 X No Specify WHITE Completed by 3

Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4or 5+) NURSE HEALTH_CARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental UNOBTAINABLE UNOBTAINABLE UNOBTAINABLE UNOBTAINABLE ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIRELLE TAUB / NIECE 309 WEST SEAMAN AVENUE - FREEPORT NY 11520
Date Proposition (Name of Discosition - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RIVERSIDE 06/27/2007 | ROCHELLE PARK, NJ 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Mitt Leu 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) COTONA Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes certificate has been si rector, page 2 should Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2∏ No 1∏Yes 1∐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No 1 ☐ Yes 1 | Inpatient 2 ER/Outpatient ို 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated | Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at the time. 29a. Certifier Medical (Check only one) Medigal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 200-430 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rodney Biglow, MD Northwest Hospital Randallstown, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 2007 Registrar

29d. Date signed (Month, Day, Year)

Medical State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of certifier of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 11:02AM HOWARD FRANKLIN DOWLING 2007 /Medical Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** SAMARITAN BALTIMORE N/A If Under 1 Year It Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. August 28, 1911 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** XX M 20 F 216-05-4952 95 Yrs. Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Examination invitible of XXYes 2□No Completed by Funeral Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 731 East Lake Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? XXIYes 2 □ No WWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married and 21215-0036 1 ☐ Yes 2XXVo White Specify: XX Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) be filed within Elementary/Secondary (0-12) and Mental Hygiene.

Is marked other than College (1-4or 5+) Arsenal Foreman Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Dowling Kathleen Ogle Baltimore, Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Carol McPhee PR permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. 731 East Lake Avenue Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Grans 6/28/07 Timonium Maryland □Donation 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home II ignature of Funeral S 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Assiration Due to (or as a consequence of disease or condition resulting in death) pneumonia /Medical **Examiner** Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Medical Certification; To Be Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably nodule 24a. Was an 24b. Were autopsy findings available prior to completion of cause of lung prior to completion death? perforn 2 No 1 Yes 1 Yes 25. Was case referred to medical examiner? completely filled in by the funeral director, 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other. 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred Injury at Work? After 5 Pending investigation 1 Yes 2 No 2 Accident after death 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D0062735 mD June, 23, 2007 h 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) och Raven Blvd. Baltmore, MD 21239 5601 Jonna MD parna 32 Registrar's Signature 31. Date filed (Month, Day, Year) JUN 2 7 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

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State of Maryland? Department of Health and Mental Hygiene

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N. Carlot	/Medica	I TELEN TO	WSON		4b. City, Town, or Loca	V 11	-07	B.35AM
A	Examine	A		1.1.	7		4c. County of De	eath
	Funeral	5. Social Security Number 6. S		inthday) If Under 1 Year		Date of Birth (Month, Day, Yea	9. E	Birthplace (State or Foreign Country)
	Director	246-44-4781	□M 2 X F 70	Yrs. Months Days	Hours Min.	4-12-3	37 N	·Carolina
	fand	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
	the Marylar 28a-f show nortified at	MD	Ba	ltimore				1 🗷 Yes 2 🗆 No
	or 28	10e. Street and Number	3000	10f. Zip Code		10g.	Citizen of What	Country?
	ath w	1609 E. 3045	street	212			USA	4
_	ter daa ittems ingr.m	10e. Street and Number 10e. Street and Number 11. Maritel Status 1 Never Married 2 Married	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No	13. Was Decedent of H If Yes, specify Cuba	lispenic Origin? (Spec an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ai Black, W	merican Indian, hite, etc.
21215-0020	72 hours after death with the Maryland instural; or items 23s or 28s-f show dical Examiner must be notified at	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀 No	Specify:		Specify:	Black
5-0	72 hours natural',	3 Widowed 4 Divorced 15. Decedent's Expecify only highest grades to the secondary (0-12) 17. Father's Name (First, Middle, Last)	ducation 16a	a. Decedent's Usual Occup	pation during most of working	16b.	Kind of Busine	ss/Industry
121	C	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retired		<u> </u>	I on KI	h Cam
d 2	ba filed v	17. Father's Name (First, Middle, Last)		Vurses F	18. Mother's Name (First, Middle, Maid	len Sumame)	nare
an	ld ba ental ked o	John Dans	SON			a Br	~.^.	
Maryland	should I	19a. Informant's Name/Relationship	Variand dampter	b. Mailing Address (Street			y or Town, State	e, Zip Code)
X	and 2 salth a 27 ls	Michelle Will	IAMS 6	Moline	Grde.	Essex,	MD	21221
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any Injury or other traumatic event, the Modes.	20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐		of Disposition (Name of ery, crematory or other plac	сө)		Location - City	
ţ	t. Pag tment tant:	4 ☐ Donation 5 ☐ Other (Specify	Evera	reen emet	on G	23/07 (vergre	DEN, N.C.
Bal	permit. Departr Imports any Inje	21. Signature of Funeral Service Licen	see &	22 Name and ddle	T Cacili Gret	ne tu	Heral	Services
		Can Part Francisco	· suc	49054	onwild.	Balto,	MD ?	21212
	Physician	23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each line.	not enter the mode of ayir	ng, such as cardiac or i	respiratory arrest,		Approximate Interval Between Onset and Death
3	/Medical	Immediate Cause (Final disease or condition	METAST	ATTIC L	0 -0 14()	ANCE	R	
-	Examiner	resulting in death)		consequence of):	0100	-/// 00		
	g it g		b					_
	The law requires that the death certificate be assecuted at has been signed by the attending physician and page 2 should be datached for use as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):				
68760,	sician sician bunis	cause. Enter Underlying Cause (Disease or injury that initiated events	C					
89	ing phy e as the	resulting in death) Last	Due to (or as a	consequence of):				
Box	attendin for use		d					1
	at tha death ce d by the attendii atached for use	Part II. Other aignificant conditiona co	ontributing to death but not resulting	in the underlying cause giv	ren in Part I.	23b. Did tobac	co usa contribu	uta to tha cauaa of death?
P.0	as that tha de igned by the a be datached the bedatached the by Dhyeic		T Loss			1 🗆 Yea	2 No 3	Probably Junknown
ds,	signe d be c		E TO THR	6		24a. Was an au	tonsy 24	b. Were autopsy findings
COL	been sibould	INILUR	E IDIM	IVE		performed		available prior to completion of cause of death?
Re	he law e has age 2					1. Yes	Millio	1 ☐ Yes 2 ☐ No
Division of Vital Records,		25. Was case referred to medical			26. Place of Death (Check only one)	7	
<u>></u>	Attending Physician: or death. betor: After this cartific by the funeral director.	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/O		4 Nursing Home	5 Residence	6 □Other (S)	pecify)
n o	After the funaral	27. Manner of Death 1 Naturel 5 Pending	(Month, Day Year)	Time of lnjury 28c. Injury Wor		d. Describe how in	jury occurred	
isic	death death ctor: / y tha f	2 Accident investigetion 3 Suicide 6 Could not be			Yes 2□No	Location (Street	and Number or	Rural Route Number,
Ρį	lor Att	4 ☐ Homicide determined	building, etc. (Specify)	ann, stroot, ractory, omes		City or Town, Sta	ate)	The state of the s
	Hospital 24 hours 25 hours Funeral taly filled	29a. Certifier 12 Certifying Phy	sician: To the best of my knowledg	e, deeth occurred at the tin	ne, date and place, an	d due to the cause	(s) and manner	as stated.
	To the Hospital or I within 24 hours after To the Funeral Dire completaly filled in E		Inar: On the basis of exemination are and manner stated.			,		
	within 2 vithe comple	29b. Signature and title of certifier	· AH · ·	29c. Licens	e number	29d. (Date signed (Mo	onth, Day, Year)
		Rittmand	of morenam	\$ 150	0503	6	11716) †
	10	30. Name and address of person who o	completed cause of death (Item 23e)	MO SIGN	u Rolli	y Rd	SH 7-	5,21228
	State	31. Date filed (Month, Day, Year)	37 Registrar's Signature	had a	3 , 300, 1	1	J. (W	10 01000
	Registrar	JUN 2 7 280	7 Baren D.	A THE STATE OF THE				

Physician Medical Examiner Medical Examiner 1. Decedent's Name (First, Middle, Last) Leroy Herman Edwards Jr. 4a. Facility Name (if not institution, give street and number) Sinai Hospital Funeral Director Funeral Rever Mariae 2 Mariae Grant Ruman Funeral Ruman Funeral F	58
Leroy Herman Edwards Jr. June 23, 2007 1829 nrs	
Funeral Director 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) N.J. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City 1 Yes 2 Yes 2	\dashv
Director 141-66-3007 1X M 2 F 41 Yrs. Months Days Hours Min. 7/18/1965 Foreign Country NJ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City 1 Yes 2	-
10a. State 10b. County 10c. City, Town or Location 10d. Inside City	_
MD Anne Arundel Glen Burnie MD Anne Arundel Glen Burnie 106. Street and Number 106. Street and Number 107. Zip Code 108. Citizen of What Country?	
10e. Street and Number 8039 Greenleaf Terrace, Apt. T2 10f. 21061 NO	
The state of the s	
Specify: Specif	٠.
Properties and the state of the	an
Proposition of the proposition o	12 1
The second secon	
To go a graph of the control of the	
N 5 5 E 5 P 198. Informants Namer Relationship (Type, Print)	16.1
Brenda Edwards/ wife 8039 Greenleaf Terrace, #T2, Glen Burni	T
Brenda Edwards / wife 8039 Greenleaf Terrace, #TZ, Glen Burn1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State	
200. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 21 Janature of Funeral Service Lifensee 22 Name and Address of Facility Wylei 1 Pd. A. of Balt 1 Donation 5 Other Specify: 22 Name and Address of Facility 23 Name and Address of Facility 24 Pandalls town MD 21	
MANO LIDERLY RU. Randall'Stown, Ind 21	133
Physician 23a. Part I. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only, one cause on each line. Approximate I Between Ons	
Immediate Cause (Final disease or condition resulting in death) Death	
Sequentially list conditions, If any leading to immediate Due to (or as a consequence of):	
cause. Enter Underlying Cause C. Chisease or injury that initiated	
events resulting in death) Last Due to (or as a consequence of):	
AMENDED X AMENDE X AMENDED X AMENDE X AMEND X AMENDE X A	
So to	ır
WINDENDED X MENDED X MEN	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death part II.	
Described as a second property of the part II. Other significant conditions are contributed to the cause of death of the past 12 months? Value Va	
24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No 2 N	
	No
26. Was case referred to medical examiner? 1 Very sea 2 No Series of Death (Check only one) 26. Place of Death (Check only one) 26. Place of Death (Check only one) 1 Very sea 2 No Series of Death (Check only one) 1 Very sea 2 No Series of Death (Check only one)	
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year)	
Yes 2 X No unk Natural 2 Accident Investigation Investigation Investigation Street and Number or Rural Route Numb	r. City
24a. Was an autopsy performed? 1	
29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Registrar's Signature	
DHMH 17 Rev 1/2001 OCME ORIGINAL OCME 2006	

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State of Maryland / Department of Health and Mental Hygiene 2 UU7

		1	For State Registrar	nale of Maryland		tificate of L			leg. No.	007		
F	Physicia		I. Decedent's Name (First, Middle, Last) William		Fnng			2. Date of Dea Month	Day	Year	3. Time of 4:57	
4	/Medic	al _		and and any art and	Epps	4b. City, Town, or	Location of Death	JUNE		2007 Inty of Death	4-31	
1	Examin	SI .	ta. Facility Name (If not institution, give stre	/	PLIAL	B	ALTIM	ORE		NA		
*	Funeral Director	500	5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day)	9. Birthp Cour	lace (State o etry) Va	r Foreign
	/land low at		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside Cit	,
	a-f sh	ctor	Md. NA		Balti							20110
	or 28 or 28 be no	Dir	10e. Street and Number			10f. Zip Code 2123	2.4			of What Cour	iti y :	
	eath v	eral	1260 Halstead Rd.	. Was Decedent Ever in U.	S. 13. \	Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No-		Race - Americ		
336	2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		f Yes, specify Cuba 1 □ Yes 2 X N o	n, Mexican, Puerto	Rican, etc.)		Black, White, ecify: B	etc. lack	
Maryland 21215-0036	72 ho "natur dical l	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. Deced (Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work f)	king	16b. Kind	of Business/In	dustry	
121	within ene. than he Me	dwc	Elementary/Secondary (0-12) 4th grade	College (1-4or 5+)		road Div.	•		Beth	lehem	Steel_	Corp.
9	illed I Hygi other ent, t	Be Co	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Su			
/lan	uld be Menta arked artic ev	10 B	Lazarus	Epp	s		Helen				okes	
lar)	2 sho and ls ma rauma		19a. Informant's Name/Relationship (Type			ng Address (Street 260 Halst				_	1.234	
e,	ges 1 and 2 should it of Health and Mer If Item 27 Is marke or other traumatic	-	Linda Epps D	aughter 206. F		osition (Name of matory or other place		Date		ion - City or T		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra once.		1 Burial 2 □ Cremation 3 □ Read 4 □ Donation 5 □ Other (Specify)	noval from State Ar	butus	Mem. Parl	6-2	8-07		itus ,M	d.	
Ball	permit Depar Impor any In once,		21. Signature of Funeral Service Licensee	Wane	C	1101 E. N	North Ave	March F ., Balt	imore		21202	
	Physician and physician and as the burial-transit	l Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) a. Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	Quence of): ARY Quence of).	SNFA	RCTION	J	rrest,		Approximatinterval Bei	tween
). Box 68760,	eath certif attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome pf pregn 1 □Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	□Ectopic pregnanc	у		230	d. Date of deli	very Day	Year
ls, P.O.	w requires that the d been signed by the should be detached		Part II. Other significant conditions conf	INDU RI	FED	HYPOT	ENSION			contribute to		death?
or Vital Records,	law requires been s	Completed by	RENAL FAIL	URE, F	NEUI	MONIF	1	24a. Was	psy ormed2/	24b. Were au prior to death?	ompletion of	available cause of
三田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田田	sician: The law certificate has irector, page 2		1 - 111	SCULAR	DIZ	EHZE	OC Plans of Do	1 Yes ath (Check only	2 No	1 □ Yes	2 No	
Vit	sician: certific irector,	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	ospital: 1 Inpatient 2	TER/Outpatie	ent 3 DOA Ot	hor:	Home 5□ Res		□Other (Spec	cify)	
ion or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	tion: To	27. Manner of Death Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c. Inju	iryat irk?]Yes 2∐No	28d. Describe	how injury	occurred		
Division	lor Atterdes afterdes Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At I building, etc. (Spec	nome, farm, s sify)	treet, factory, office		28f. Location City or To	(Street and own, State)	Number or Ru	ıral Route Nu	mber,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier Chack only one)	ician: To the best of my kr ler: On the basis of examin and manner stated.	nowledge, dea	ath occurred at the finvestigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time	e cause(s) a e, date and p	and manner as place, and due	stated. to the cause	(s)
	To the within To the complex	Me	29b. Signature and title of certifier				se number			signed (Mont		
			Shaun	MD			ES000		JUN	E, 23	200	7
	87		30. Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type	RAVEN	BILL	BALT	imo	RE	m > =	1123
	U	oto	ROSHAN DHAWM 31. Date filed (Month, Day, Year)	32. Pegistrar's Sign	nature	KAUEIO	00013	DHU			1-70 0	40
	S ^o Regis	trar	TIIN O W 20	3000	2	1-12						

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event; the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Funeral Director

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Dhysisi		1. Decedent's Name	e (First, Middle	e, Last)								2. Date of De Month	ath Da	ay Year	3. Time of Death
Physici /Medic		Nancy		Ann			F.	Lowers						2007	12:14 P ^M
Examin	er	4a. Facility Name (I	f not institution	, give street a	nd number,			4b. City, T	own, o	r Location	of Death		40	. County of Deat	h
		Holy Cro 5. Social Security N		pital 6. Sex	17 A	/l	lo o 6 h i a 6 h a la .	Silve			ළ r 24 Hrs.	8. Date of Birt		lontgome	
uneral irector		243-92-0		1 □ M 2		55	last birthday Yrs.		Days	Hours		(Month. Da	v. Year.) (co	hplace (State or Foreign untry) h Carolina
ilector		Usual Residence of										Jan 14	, I.	JJZ NOIL	ii Galulina
at		10a. State	10b. County			10c. City	, Town or I	ocation							10d. Inside City Limits
a-f sl	ctor	MD	Montgo	omery		Sil	ver S	pring							1X Yes 2 No
or 28	Director	10e. Street and Nur						10f. Zip (,			10g. Ci	tizen of What Co	untry?
23a nust b		14109 Ca	stle Bl						ი9ი					SA	
items ner m	Funeral	 Marital Status Never Marri 	X	Arm	Decedent	,	S. 13	. Was Decede If Yes, speci	ent of F fy Cub	lispanic O an, Mexica	rigin? (Spe an, Puerto	ecify Yes or No Rican, etc.)	-	 14. Race - Amer Black, White 	
Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by F	3 ☐ Widowed		If Y	Yes 2 🗖 es, Give rorDates:	INO		1 ☐ Yes 2	ŊNo	Specify	<i>/</i> :			Specify: p.1	0.01
atura cal E			15. Decedent	's Education			16a. Dec	edent's Usual	Occup	oation			16b. K	L D /(ind of Business	Lack
Medi	Completed	Elementary/Seco	ndary (0-12)		eted) ege (1-4or	5+)	(Giv life.	e kind of work DO NOT use	done retire	during mo d)	st of worki	ing			
the th	Ö			2			Nur	sing					M	edical	
doth	Be (17. Father's Name		Last)						18. Moth	ner's Name	(First, Middle,	Maider	n Surname)	-
arke atic e	ဥ	Gerald N	ewton								nie S				
is m		19a. Informant's Na					19b. Mai	ling Address (Street	and Numl	ber or Rura	al Route Numbe	er, City	or Town, State, Z	(ip Code)
am 27 ther t		Calvin S 20a. Method of Disp	-000 \	Nephew)	20b B		9 Rive		irch		North		son, NC	27896
or of		1 ⊠ Buriat 2 l	Cremation		from State	C	emetery, cr	ematory or oti	her pla				20c. L	ocation - City or	Iown, State
rtant		4 □ Donation 21. Signature of Fu				Sur		lemoria				nes Fur		rmville,	NC
any i		21. Signature of Fu	neral Service	Ligensee	. 4	\cap	'	zz. Name and	Adare						111 110
		23a. Part1 Errer ti	ne disease. or	complications	that cause	the death	ı. Do not e	nter the mode	of dvir			THE RESERVE AND ADDRESS OF THE PERSON		ka. Farm	nville, NC
afala		she k, hea Immediate use (rt failure. List	only one caus	e on each I	ne.		400	a a		1	or reaphatery an	, ,	Î	Approximate Interval Between Onset and Death
sícian ledical		disease or condition resulting in death)	n	a	olor as	a o nsequ	Inne of:	UK	y.	1-01	1/				
aminer					7 4	PNI	AC.	AR	RE	ST	-				
S. C. C.	Jer	Sequentially list con if any, reading to infi- cause. Enter Unde Cause (Disease or	nditions, mediate	b	ue to (or as	a consequ	rence of):	Λ. Λ.	100		-				
attending physician and for use as the burial-transit	Examiner	that initiated events		c. (10R	ONA	1 RX	A	RT	ERY	Y J	DISEA	458	ا ع	
ian ar ırial-t		resulting in death) L	.ast	D	ue to (or as	a consequ	ence of):								
hysic the bi	lica			d											
ding p	cian/Medical	IF FEMALE:		00-16									-1		
or us	ian/	23b. Was decedent in the past 12		1 1		2 Fetal	death 3	□Ectopic pre		У	N/A			23d. Date of deli Month	very Day Year
the s		1 ☐ Yes 2 ₹ 9 ☐ Unknown	No	9	Pregnant a Unknown	t time of de	eatn 5	Other (spe	city) _						
ed by detac	Physi	Part II. Other, signif	icant condition	ns contributin	to death b	ut not resu	ilting in the	underlying ca	use giv	en in Part	I.	23e. Did to	bacco	use contribute to	the cause of death?
sign d be	d by	Uni	Know	n			•								obably 4 □Unknown
beer	ete											24a. Was	an	24h Word au	to you findings available
e has	Completed											autor perfo	sy rmed?	prior to death?	topsy findings available completion of cause of
ifficat or, pe	e C	25. Was case refer	red to medical							26 Place	o of Dooth	1 Yes ∩ (Check only o		1 □ Yes	2 🖾 No
s cert direct	To B	examiner? 1 ☐ Yes 2 🔀		Hospital:	1 🗌 Inpati	ent 2 Tst	ER/Outpatie	ent 3 □ D O A	Oth	or.				6 ☐Other (Spec	nife()
er thi		27. Manner of Death		,	Date of Inju	ıry	28b. Time		c. Injur Wor			28d. Describe h			ary)
r: Aft	atio	1 X Natural 2 ☐ Accident	5 ☐ Pending investig		(Month, Da	y rear)	Injury	М		Yes 2□]No				
recto	iệi	3 ☐ Suicide 4 ☐ Homicide	6 □ Could r determi		Place of in			treet, factory,	office		1	28f. Location (S City or Tou	Street ar	nd Number or Ru	ral Route Number,
ral Di	Certification:					_	<u> </u>								
To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached		29a. Certifier (Check only	1 ☐ Certifyin 2 ☐ Medical	Examiner: n	the basis of	f examinat	wledge, dea tion and/or i	ith occurred a nvestigation,	t the tir	me, date a opinion, de	ind place, eath occurr	and due to the ed at the time.	cause(s date an	and manner as	stated. to the cause(s)
the mplet	Medical	one)	/	1 th	manner s	ated.				e number					
2 00	-	29b. Signature and	Sor certifier	///	///	1		290.	× -		- 1		∠ag. Da	ite signed (Month	
1		-50	ul)	XX K	1/4				2	56 S	06		1	me 18	,200/
		30. Name and addre Eunice S	ess of person hakir,	who completed MD K	dause of a	leath (Item Pern	^{23a)} (Type lanent	e 6104	01	d Bra	anch	Ave. Te	mp1	e Hīlls,	MD
Sta	to	31. Date filed (Moni			32 Regist		ture						1		
Sta Registr			JUN 2 7	2007	A Section		y A	2346							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Audrey Jean Forsyth 2007 June 22, /Medical 3:45P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Heritage Meridian Ctr. Dundalk <u>Baltimore</u> 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 M 2 F 217-32-6353 72 17,1934 Pennsylvania Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 XNo Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3919 Glenhurst Road 21222 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify. Completed by 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) 11 Years Data Processing Police Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Burnsworth Sanah Silbaugh မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3919 Glenhurst Road Diana Marshall (Daughter) Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Ht. of Jesus Cem. 6/26/2007 Dundalk, Maryland 22. Name and Address of Facility 21. Signatur Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, shock, or heart failure Immediate Cau a Tinal disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnam 3 ☐ Ectopic pregnancy in the past 12 mor 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform To the Hospital or Attending Physician: within 24 hours after death. Be 25. Was case referred to medical examiner? 26. Place Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Tyes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of D r of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be within 24 hours after dec To the Funeral Directo completely filled in by th 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature an 29d. Date signed (Month, Day, Year) the of certifier 29c. License number 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 2007 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner enotous IMOTE If Under 1 Year
Days OW Date of Birth (Month, Day,) Year If Under 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday Year) 1916 **Funeral** Hours Months Ohio 1 □ M 2 🙀 F 91 Feb. 278-18-4302 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 ▼No Maryland Prince George Clinton Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.

int; If Item 27 is marked other than "natural", or Items 23a or: USA 20735 6011 Alan Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or items traumatic event, the Medical Examiner mu 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💆 No Specify: Saltimore, Maryland 21215-0036 Specify. White þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Chief of Staff 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Lewis Charles A. Hopkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important; If Item 27 is any injury or other trauonce. 6011 Alan Drive, Clinton, Maryland 20735 Renate S. Schorsch / 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/28/2007 Bladensburg, Maryland Ft. Lincoln Ceme. 5 ☐ Other (Specify) Donation 22. Name and Address of Facility Hubbard Funeral Home, Inc. of Funeral Service Licensee 21. Cignatu 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician eroscle /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner al or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FFMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 Probably 4 → hknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 4☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 | N 1 Inpatient Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

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ASSELL

711 Marden

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 3:45 June 24, 2007 /Medical Edgar Leo Gise, Sr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner n/a Baltimore Joseph Richey Hospice Year If Unde Hours 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 2 M 2 □ F Yrs 5/1/26 Maryland Director 81 219-16-8811 2 should be filed within 72 hours after death with the Maryland i and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21207 2113 Lorraine Avenue Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 M No Baltimore, Maryland 21215-0036 Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced White WW II 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Paint & Brush Company 0 Supervisor 8 18. Mother's Name (First, Middle, Maiden Surname) Item 27 Is marked othe other traumatic event, 17. Father's Name (First, Middle, Last) Be <u>Bertha Fredericks</u> ပ Ernest Franklin Gise 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Health tem 27 I Baltimore, Maryland 21207 Mrs. Ruth N. Gise / Wife 2113 lorraine Avenue Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, Maryland 6/28/07 Lakeview Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. Baltimore, Maryland 21229 plications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. 23a. Part1. Fiter the disease, or shock, ir heart failure. List Immediate Cause (Final 006-140 Physician disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of law requires that the death certificate be executed Exami physician and s the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) ☐Yes 2☐No P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONIC OBSTRUCTIVE PULM ANARY Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an DEMENTIA autopsy performed? Yes 2 No page 2 certificate 1□ Yes Division or Vital 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Dother (Specify) HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death 1 Natural funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P after death. I Director: After After 1 Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours a To the Funeral I Hospital

> State Registrar

of person who completed cause of death (Item 23a) (Type, Print)

CAMPARE, COLUMBIA, MD 21045

DO\$ 26327 JUNE 24, 2007

Day, Year) 31. Date filed (Month, Day,

29b. Signature and title of certifier

		for State Registrar	Stat	te of Ma	aryland /		artment of F		nd Mei		giene Reg. No.	2007	20687
		Decedent's Name (First, Mid	Idle, Last)		,				2.	Date of Dea			3. Time of Death
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/Medic		4a. Facility Name (If not institu		nd number)			4b. City, Town, o	or Location of				County of Death	
Age to		Carroll Hospit	al Cente	er			Westmin	nster				Carroll	
Funeral	4	5. Social Securify Number	6. Sex	7. Age	(In yrs. last		If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Min.	Date of Birt (Month, Day	h	9. Birth	place (State or Foreign ntry)
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and		Usual Residence of Decedent 10a. State 10b. Cour	ity	1	10c. City, To	wn or Lo	cation						10d. Inside City Limits
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r 28a	Director	10e. Street and Number)		Man	ches	10f. Zip Code				10g. Citiz	en of What Cou	ntry?
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ems ?	Funeral	11. Marital Status	12. Was	Decedent E	ver in U.S.	13. \	Was Decedent of F f Yes, specify Cub	Hispanic Origi	in? (Specify			4. Race - Ameri Black, White	
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\$ 2 2 2 8	Be (17. Father's Name (First, Midd								irst, Middle,		Surname)	
arylar should be trid Menta s marked umatic ev	ဥ	Angus Roy Gros 19a. Informant's Name/Relation		t)	11	9h Mailin	g Address (Street	Anna I				Town State 7	Cada)
	П	Adrienne R. Gr					Lineboro					Maryland	
O - 1 1 1 2		20a. Method of Disposition			20b, Place	of Dispo	sition (Name of natory or other place		Date	9		cation - City or T	
Pages nent of I		1 ☐ Burial 2 XX Crematio 4 ☐ Donation 5 ☐ Other	3 □Removal (Specify)	from State	1		matory		une 3 007	0,	ator	nevilla.	Maryland
Baltimo permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Sapri	e Licensee	+	rietro	22	. Name and Addre			ardt F	uner	al Chap	el, P.A.
n 88 5 5 8		SAMO OC	main	5 -			3296 Char	mil Dr	rive;	Manch	este	r, Mary	land 21102
		23a Part F ter the disease, shork, or heart failure. L	or complication	that caused	the death. Dee.	o not ente	er the mode of dyir	ng, such as c	ardiac or re	espiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disea or condition resulting in death)	_a. K	und	ure	00	bdomi	nal a	rorti	c al	1011	rysm	Onset and Death Minutes
/Medical Examiner		resulting in death)	Di	ue to for as a	consequenc	e of):						/	
100	P.	Sequentially list conditions,	b	se to for as a	t Consequenc	e oft							
uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1										
cate be executed physician and the bunial-transit	Exa	resulting in death) Last	C. Du	ue to (or as a	consequenc	e of):							
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death certific	sician/M	23b. Was decedent pregnant in the past 12 months?	1 0	Live birth 2	of pregnancy 2 Fetal dea	ıth 3□	Ectopic pregnancy	y			2	3d. Date of deliv	•
the deg	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Pregnant at t Unknown	time of death	5 🗆	Other (specify)					Month	Day Year
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VITAI HE ician: The lav certificate has ector, page 2	ပို့ .	25. Was case referred to medi	ral					00 81	15 11 12	1 Ves	2□No	1 Tes	2□ No
	0 0	examiner? 1 Yes 2 No	Hospital:	1 Inpatien	nt 2 ER/C	Outnatien	t 3□ DOA Oth			heck only of		□Other (Speci	E.A.
	-	27. Manner of Death		Date of Injury	y 28b	. Time of	28c. Injur Wor			. Describe h			y)
Attending Phragation of Attending Phragath. ector: After the by the funeral	atio	Z L / tooldelit	stigation	(монт, рау	rear)	Injury		Yes 2 □ No	0				
	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	mined 286.	Place of injur	ry - At home, (Specify)	farm, stre	et, factory, office	111	28f.	Location (S City or Tow	treet and	Number or Run	al Route Number,
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To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier 1 Certific (Check only one)	al Examiner: On	o the best of the basis of manner stat	examination a	ge, death and/or inv	occurred at the tir restigation, in my o	me, date and opinion, death	place, and h occurred	due to the dat the time, d	ause(s) a date and	and manner as s place, and due t	stated. o the cause(s)
To tl Vithi To tl comp	Ž	29b. Signature and title of certi	ier ///		//		29c. Licens	e number		1	29d. Date	signed (Month,	Day, Year)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Garvin 14:15 M 18 Annie June 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimone The Johns Hopkins Hospital CIty Date of Birth (Manth, Day, If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 M 2 1 F Director Usual Residence of Deceden 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Show notified at 1 es 2 No Director 28a-f timore 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code ir than "natural", or Items 23a or the Medical Examiner must be Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 🗶 No Specify. þ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) condary (0-12) College (1-4or 5+) iges 1 and 2 should be filed vorted the siled vorted the sile of Health and Mental Hygie is the sile of the sile o 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister E.N. Kita Turne 08 Balto-MID21214 Sa 20-NL Important: If item 2 any injury or other Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Date 20c. Location - City or Town, State Pages 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State edar Hill Cemeters Itinore, MD 21. Signetyre of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of swing, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate interval Between Onset and Death Immediate Cause (Final Hypotension **Physician** days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Variceal bleeding days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Liver failure be executed burial-tran Due to (or as a consequence of) attending physician for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical as asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 Yes 2 2 No 2**X** No Attending Physiclan: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No ို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. **In**jury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After it ⊤**®**Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Shuyama Mudale, Medical Doctor RES-000 20 2007 June 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Mudali The Johns Hopkins Hospital, 600 N. Wolfe St, Baltimore MD 21287 Shiyama 31. Date filed (Month, Day, Year) JUN 2 7 2007 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

10

31. Date filed (Month, Day, Year) State Registrar

82. Registrar's Signature

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

ZUBAIR SHAIKH GOOD SAMARITAN HOSPITAL, 560LOCH RAVENBLYD, BALTIMORE, MD 21239

RES-000

JUNE

2007

		•	For State Registrar	State of I	Maryland /	Depa <i>Cei</i>	artment of rtificate of	Health Death	and Me		iene eg. No.	07	20690
	Physici	an	1. Decedent's Name (First, Middle, L							2. Date of Deat Month		Year	3. Time of Death
	/Medic	al	ELIZABETH JAMISO		1		4h City Town	as I asstina		June 25		v of Death	8:20 p. M
	Examin	er	4a. Facility Name (If not institution, g. Edenwald	ve street and numb	er)		4b. City, Town, Tow		of Death			imore	
	Funeral	4			Age (In yrs. last b	irthday)	If Under 1 Year	If Under		B. Date of Birth		9. Birth	place (State or Foreign
u	Director		214-03-1851	1□ M 2√X	91	Yrs.	Months Days	Hours	Min.	oct. 2,	1915	New	York
	pu &		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wnorlo	cation						I Od. Inside City Limits
	Maryli f sho	ō		ro	,	vson							1 ☐ Yes √2√√ No
	28a-	rect	Maryland Baltimo	ole	100	VSULL	10f. Zip Code			1	0g. Citizen of	What Cou	2323
	th with	Funeral Director	800 Southerly F	Road			2128	6			U.S.	Α.	
	ams er	ıner	11. Marital Status	12. Was Decede Armed Force 1 \(\superscript{Yes} 2	ont Ever in U.S.	13.	Was Decedent of If Yes, specify Cul	Hispanic Or pan, Mexica	rigin? (Spec n, Puerto R	ify Yes or No- ican, etc.)		ce - Ameri	
36	s afte	ьу Fu	12 Never Married 2 Married 3 □ Widowed 4 □ Divorced	1 ☐ Yes 22 If Yes, Give Year or Date			1□Yes XXN				Speci	ity: W	hite
8	within 72 hours after death with the Maryland ene. than "natural", or itams 23a or 28a-f show the Medic Exs. circl mat Le notifie de	edit	15. Decedent's	Education			dent's Usual Occu				16b. Kind of I	Business/In	dustry
215	hin 72 e. an "na Medi	Completed	(Specify only highest g Elementary(Secondary (0-12)	rade completed) College (1-4	or 5+)	(Give life.	kind of work done DO NOT use retire	ed)	st of working	9	-	1 .	
21	filed wit Hygiene thar than	Col	12				Secreta					1 Est	ate
Maryland 21215-0036		Be	17. Father's Name (First, Middle, Last Charles Hardwo		,					(First, Middle, 1 $ m Se11~St$			
Ž	2 should be and Mental Is marked sumatic av	2	19a. Informant's Name/Relationship			b. Mailir	ng Address (Stree			* ***			Code)
Ma	nd 2 saith ar 27 is rrtrau		Betsy Morgan	(Niece)	3		chanan R				-		
Baltimore,	as 1 and 2 of Health fitam 27 r other tr	17	20a. Method of Disposition 1 Burial XXCremation 3	Domovoi from St	000000	of Dispo	sition (Name of natory or other pl	ace)	Da	ite	20c. Location	- City or To	own, State
Ë	Pages ment of I ant: If its ury or o	1	' 4 □ Donation 5 □ Other (Spec		Greer		unt Crem						
3alt	perr it. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Lic	The the		22	2. Name and Add						
	40280		23a. Part1. Enter the disease, or co shock, or heart failure. List on	molications that one	d the death. Do	not ent						ryıan	d 21212 Approximate
	Pnysician /Medical Examiner		snock, or near failure. List on Immediate Cause (Final disease or condition resulting in death)										Interval Between Onset and Death
,0,	death certificate be executed eattending physician and id for use as the burial-transit	Examiner	Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (cr	as a consequence	e of):	TOPIC	CP	23 17	IU UM	3000	m,	11tom
x 68760,	eath certificate b attending physic for use as the b	ian/Medical	IF FEMALE:	d23c. If yes, outco	me of pregnancy								
.O. Box	the y th	Physician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 ☐ Live birtl	n 2 ☐ Fetal dea t at time of death		Ectopic pregnant Other (specify)	СУ				ate of deliv	Day Year
rds, P	The law requires that te has been signed b rage 2 should be deta	by	Part II. Other significant conditions	contributing to deal	h but not resulting	in the u	nderlying cause g	iven in Part	l,	23e. Did to		ntribute to t 3 ☐ Prol	he cause of death? pably 4 □Unknown
Vital Records,		Completed								24a. Was a autops perform	sy	prior to co death?	opsy findings available impletion of cause of
Vita	Physician: This certifical	Be	25. Was case referred to medical examiner?	Hospital:				la an	341	(Check only or			
of		To to	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inp	niury 28b	outpatier . Time o	f 28c, Inj	ury at		e 5 🗌 Reside			(y)
Ion	Attending Ph r death. ector: After thi by the funeral	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		Day Year)	Injury	W	ork? ∐Yes 2.[]No				
Division	E Sign	Certification;	3 Suicide 6 Could not determine	A 200. Flace of	Injury - At home, , etc. (Specify)	farm, str	reet, factory, office		28	Bf. Location (Si City or Town		ber or Run	al Route Number,
	To the Hospital within 24 hours a To the Funeral completely filled	edical		Physician: To the beaminer: On the basi and manner	s of examination a								
	with To t	Σ	29b. Signature and title of celtifier					ise number			9d. Date sign		
7	10		Jul Jul	an			117	٢78	38	3	UNITS	24	,2007
	Ψ		30. Name and address of person wh	o completed cause	or death (Item 23a	(Type,	Print)	אור מי	20 1	an' (.	. 7	21	090
	Sta Registr		31. Date filed (Month, Day, Year)	100	strar's Signature	2	hould	y	115 V	, -1	MITIC		y 14.7
			N	Took.	A complete and a second	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 21, June 2007 12:20 AM Hannah Eddie 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Charlotte Hall Charlotte Hall St. Mary's If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Mississippi 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Months Days Hours 124M 2□F Yrs. 426-38-2948 93 Oct. 6, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1⊈ Yes 2 □ No MD St. Mary's Charlotte Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 29449 Charlotte Hall Road 20622 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∰Yes 2 ☐ No If Yes, Give 1943 Year or Dates: 1.0. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black to 3 Nidowed 4 Divorced 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Barber Self Employed 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Iland Jim Henry Hannah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Erma Jean Lee - Daughter 5904 S. Gate Drive Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Columbus, Mississippi Union Cemetery `4 ☐Donation, 5 ☐ Other (Specify) 6-28-07 22. Name and Address of Facility Carter Funeral Service 21. Signature of Funeral Servicerticensee P.O. Box 1441 Columbus, Mississippi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final antal Coroman disease or condition resulting in death) Due to (or as a consequence of onges hie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sia ye Due to (or as a consequence of) FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown 23a. Did tobacco use contribute to the cause of death? તુ (!, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 **N**0 3 Probably 4 □Unknown 1 🗀 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2XNo Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work?

29c. License number

D57574

1 ☐ Yes 2 ☐ No

Pnysician /Medical **Examiner**

The law requires that the death certificate be executed

Box 68760.

P.0.

Division of Vital Records,

the Hospital or Attanding Physician:

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After

within 24 hours a To the Funeral C

Department of himportant: If its any injury or ot once.

Physician

/Medical

Examiner

Funeral

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Pages 1 and 2 should be f nent of Health and Mental I int: If itam 27 Is marked of

Director

Completed by Funeral

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other traumatic avent. If a Modical Examinar must be notified at

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

27. Manner of Death ical Certification:

burial-transit the as after death.

I Diractor: Af
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cian/Me	1F 23
Physi	Par
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Compl	-
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1 Natural

2 Accident

4 Homicide

3 Suicide

29a Certifier

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

21

20895

29d. Date signed (Month, Day, Year)

[o]

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

28a. Date of Injury (Month, Day Year)

10810 Connecticut Ave., Kensington, MD

31. Date filed (Month, Day, Year) JUN 2 7 2007

Ahmed Heshmat, MD

82. Registrar's Signature

2

State

Registrar

		1	For State Registrar	State of Maryl		artment of Health a rtificate of Death		giene 007	20692
	Physicia	ın	1. Decedent's Name (First, Middle, L.) Wesley	Hall			2. Date of De Month	Day 20 Year	3. Time of Death 6- 25 #M
	/Medic Examin		la. Facility Name (If not institution, gi		Rehno	4b. City, Town, or Location of		4c. County of Death	
	Funeral Director	4	578 36 0612	Sex 7. Age (In)	7 Yrs. last birthday)	If Under 1 Year If Under Months Days Hours	Min. B. Date of Bir	orth 9. Birth ay Year) 5. Co	nplace (State or Foreign untry)
	the Maryland 28a-f ehow		Usual Residence of Decedent 10a. State 10b. County	/n 10c	City, Town or Le				10d. Inside City Limits Yes 2 □ No
:	with the R a or 28a- be notifi	Direct	10e. Street and Number 52 25 DENHOR	live.		10f. Zip Code		10g. Citizen of What Co	untry?
36	n 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f ehow adical Examiner must be notified at	-	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed ★ Divorced	12. Was Decedent Ever Armed Forces? 1 2 es 2 No If Yes, Give Year or Dates:		Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexicar 1 ☐ Yes 2☐ No Specify:		o- 14. Race - Amer Black, White	o, etc.
ις	within 72 hou iene. 'then "natura ins Medical E	Completed	15. Decedent's Is (Specify only highest g Elementary/Secondary (0-12)	Education	(Give	dent's Usual Occupation e kind of work done during mos DO NOT use retired)	t of working	16b. Kind of Business/	playes
70	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, ILE Ma	To Be C	17. Father's Name (First, Middle, Las	it)		18. Mothe	CMI	45	
altimore, Mary	1 and Health tem 27 other tr		19a. Informant's Name/Relationship DENISE WG 9 20a. Method of Disposition 1 Burial 2 Termation 3 4 Donation 5 Other (Spec	NEV DAIGHE	b. Place of Disp	ing Address (Street and Numbing Address (Street and Numbing Consistion (Name of Immatory or other place)	Pate /	Der, City or Town, State, 2 DCTrait 20c. Location - City or Bushing was	Town, State
Baltin	permit. Pages Department of Important: If i any injury or o		21. Signature of Furieral Service Liv	ilei	5	2. Name and Address of Facility Polyster	stown ld	Poltino	e ned zivi
	- การร่างเล่า		3a. Part 1 Enter the disease, or co show, or heardailure. List onl 1 mediate Cause (Final isease or condition	nplications that caused the yone cause on each line.	death. Do not er	ster the mode of dying, such as Expiration M JHOKY	Preuma	arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner physician and the burial-transit	dical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cord) Due to (or as a cord) Due to (or as a cord)	nsequence of):	m stroke			
O. Box 68	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of del Month	iv ery Day Year
ds, P.O	uires that the d signed by the Id be detached	by	Part II. Other significant conditions	contributing to death but no	t resulting in the	underlying cause given in Part		tobacco use contribute to	
		Completed					24a. Wa autr peri 1 🗆 Yes	opsy prior to death?	itopsy findings available completion of cause of 2 No
of Vita	Physician: Th rthis certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		2 ER/Outpatie	ent 3 DOA Other: 4 N		sidence 6 Other (Spe	cify)
Division o	tending eath. or: After the fune	Certification:	27. Manne Death Natural 5 Pending investigat 2 Accident 3 Suicide 6 Could not determine	be 290 Place of Injuny -		Work? M 1 ☐ Yes 2 ☐	No 28f. Location	Street and Number or Rio	ural Route Number,
۵	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	ical	(Check only 2 Medical Ex	Physician: To the best of my aminer: On the basis of exa	y knowledge, dea mination and/or i	ath occurred at the time, date a nvestigation, in my opinion, de	ath occurred at the time	e, date and place, and due	to the cause(s)
	To the within 2.	Med	29b. Signature and title of certifier \$ \$ Cuc 30. Name and address of person where the second seco	and manner stated.		29c. License number	0/	29d. Date signed (Mont	1, pay, Year)
3	γ		30. Name and address of person whe Raws A Saha	o completed cause of death	(Item 23a) (Type	a, Print) Luc W	ick Road	d Balhm	romayland 222
	Sta Regist	ite ar	31. Date filed (Month, Day, Year) JUN 2 7 20	07 32. Registrar's	Signature App	de			

DHMH 17 Rev 1/2001

			1 - For State State Registrar	of Maryland	•	artment of		nd Mental Hy	giene) 7	206	93
ľ	Physici	an	1. Decedent's Name (First, Middle, Last) Cfanton Holl	ins. Jr.			-	2. Date of D Month	Day	Year	3. Time of 6:28	
	/Medic		4a. Facility Name (If not institution, give street and	, ,		4b. City, Town,	, or Location of	June	19 2 4c. County	2007 of Death	0.20	Α. "
*	the state of		Caroline Home for Ho	•			nton			aroli		
*	Funeral Director		5. Social Security Number 218 60 7214 6. Sex	7. Age (In yrs. las 54	t birthday) Yrs.	If Under 1 Yea Months Day			30,1953	9. Birthi Mar	place (State on ntry) yland	or Foreign
	ס		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation		1.1			10d. Inside C	ity Limits
	Maryla f sho	tor	Maryland Caroline		eensb							2 ∰ No
	or 28a	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		ntry?	
	eath w	erall	12891 Greensboro Roa	Id Decedent Ever in U.S.	13 \		1639	in? (Specify Ves or N	U.S		can Indian,	
920	should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other then "neturel", or items 23s or 28s-f show imatic event, Ite Madical Examiner man ke mailined at	by	1 ☐ Never Married 2 🖾 Married 1 📆 Y	Forces? es 2 ☐ No , Give or Dates:		f Yes, specify Cu		in? (Specify Yes or N Puerto Rican, etc.)	Bla Specif	ck, White,	etc.	
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212	d withir	Completed	Elementary/Secondary (0-12) College	ge (1-4or 5+)	Pair		rea)		Pa	intir	ng	
Maryland 21215-0036	d tal	Be	17. Father's Name (First, Middle, Last)	11-11:	C			's Name (First, Middle		ne)		
II y la	should Ind Men s marks	ဥ	Stanton E. 19a. Informant's Name/Relationship (Type, Print)	Hollins,		ng Address (Stre		atherine De		. State. Zii	c Code)	
	t and 2 sho Health and tem 27 is mu		Danielle Hollins / I			L Greens			ensboro,			21639
altimore,	S to II		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fr	UIII SIALE		sition (Name of natory or other p		Date	20c. Location	-		1 1
i i	permit. Page Department Important: If eny injury or once.		*4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Glei	The Personal Property lies and	en Mem. Name and Add		6/22/2007 ′Gonce_Fu				
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B	Examiner		Sequentially list conditions b.									
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68760,	icate b physic s the b	dical	d									
Box (leath certifica attending pl	Physician/Me	230. Was decedent pregnant	outcome of pregnance		Ectopic pregnar	ncv			ate of deliv	,	
О.	that the dea ed by the att detached fo	ysici	1 Ves 2 No	regnant at time of deal nknown		Other (specify)			M	onth	Day '	Year
ري ص	res that t igned by be detai	by Ph	Part II. Other significant conditions contributing	to death but not resulti	ing in the u	nderlying cause (given in Part I.	23e. Did	tobacco use con	tribute to t	he cause of c	death?
ord	w require been sig should b							X	Yes 2 No	3 Pro	babiy 4 □l	Jnknown
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	ysicien: Th is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	☐ Inpatient 2 ☐ EF	3/Outpatien	it 3□ DOA C		of Death <i>(Check only</i> sing Home 5 ☐ Res		/C	HOSI	n) (Z.
Division of	nding Phys th. : After this funeral di	\vdash	27. Manner of Death 28a. D		8b. Time of Injury	28c. In W		28d. Describe	how injury occur		Acility	,
Divis	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Diractor: After this certific completely filled in by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. P	lace of Injury - At hom uilding, etc. (Specify)	e, farm, str	eet, factory, offic	θ		(Street and Numi own, State)	ber or Run	a <i>l R</i> oute Num	iber,
	To the Hospital or At within 24 hours after or To the Funerel Dirac completely filled in by	edical	29a. Certifier (Check only one)	the best of my knowle be basis of examination nanner stated.	edge, death n and/or in	n occurred at the vestigation, in my	time, date and opinion, deat	d place, and due to the h occurred at the time	cause(s) and m , date and place,	anner as s and due t	stated. o the cause(s	s)
ì	To the within 2.	Σ	29b. Signature and title of/certifier	04 1			nse number	_	29d. Date signe			
,	1		30. Name and address of person who completed of		За) (Туре.	Print)_	U 677		06/19	1200	7	
	1		DRERIC HERMANS	EN 60	901	Afin .	LANE	Dento	N, MAR	y /Au	vd 2	1629
	Sta Registr		JUN 2 7 2007	. Registrar's Signatur	dos	E.			,	r		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year **Physician** George William Harris 2007 17:30 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MEDICAL CENTER ALISBURY Wicomes KEGIONAL 6. Sex 1 2 M 2 □ F If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 73 213-30-2525 Director March 18,1934 Maryland Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2x No Selbyville Director Sussex Co. Delaware 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code a or ural", or items 23a 37578 Peartree Lane 19975 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Armed Forces: 1 Types 2 No If Yes, Give Year or Dates: 1953-61 72 hours after 1 □ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No White <u>^</u> Specify: 3 Widowed 4 Divorced if Health and Mental Hygiene. Item 27 Is marked other than "natural", other traumatic event, the Medical Exa Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore Gas filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Crew Leader Electric 12 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe Dorothy Hartzell permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic ev George Washington Harris ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Selbyville, DE 19975 37578 Peartree Lane (Wife) Doris S. Harris 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State Baltimore, Maryland 4 Donation 5 ☐ Other (Specify) Moreland Mem. Park Cem. 6/27/2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** arolia 30w disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oncey Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ence of): Examine burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of) 68760. signed by the attending physician I be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 2 □ No 9□Unknown Ö 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records. 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform Sa 2 - NO Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 8 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA o 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident I or Attend after death Director: the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifie

State Registrar DHMH 17 Rev 1/2001

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32. Registrar's Signature 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 **Physician** Month PAULE SIMONE INGBERG 21, $a^{\,M}$ June 5:05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours Days Year) 1 □ M Director 220-28-5506 86 Nov. 5, 1920 France Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 4815 Manor Lane 21042 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 22 If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify <u>Ş</u> Specify: 3 AWidowed 4 ☐ Divorced white Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) years Homemaker Own Home traumatic event, 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill timent of Health and Mental H tant: If item 27 Is marked oth 18. Mother's Name (First, Middle, Maiden Surname) Be Octave Vallet Suzanne LeBouef 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Hoffman daughter 4815 Manor Lane Ellicott City, Maryland 21042 item 27 other t 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or ± ō Ivy Hill Cemetery 6/25/2007 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home, P.A.
313 Talbott Avenue Laurel, Maryland 21. Signature of Funeral Service Licensee M00770 20707 23a. Part1. Enter the disease, of shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) attending physician for use as the buris by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 9☐Unknown Month Day Year 5 ☐ Other (specify) signed by the at d be detached for 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a Was an was autopsy performed? Yes 2/X/No has page 2 certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 6 Other (Specify) nours after death.

neral Director: After this filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury/occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely

State

31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier



29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MULL

and manner stated

Chance ST TONSON MD ZIZOF

P.O. Box 68760

Division or Vital Records,

		. For	State of Ma	ryland / Dep	artment of H	ealth and	Mental Hyg	iene	3	
		1 - State Registrar		Ce	rtificate of l	Death	R	ng. No.2	007	20696
Physic	ninn	1. Decedent's Name (First, Middle, Last	1)				2. Date of Deat Month	h Day	Yeer	3. Time of Death
/Med		Delores Elaine Ko					June 2	4, 20	07	8:15 A M
Exam	iner	4a. Facility Name (If not institution, give			4b. City, Town, or		ath		inty of Death	
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Funera Directo			_M 2月2 F	86 Yrs.	Months Days	Hours Mir		Year)	Mary	place (State or Foreign htry) 1and
		Usual Residence of Decedent					772072			
anytar show	_	10a. State 10b. County		10c. City, Town or L	ocation				1	10d. Inside City Limits 1 ☐ Yes 2 🛣 No
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fler d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ⊠ No		Was Decedent of Hi If Yes, specify Cuba		rto Rican, etc.)		Black, White,	
ours a	þ	3 N Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Spe	ecify:	White
iled within 72 hours after death with the Maryland Hygiene Hygiene then "naturel", or Items 23e or 28e-1 ehow ent, the Medical Examination contined at	Completed	15. Decedent's Ede (Specify only highest grad	ucation de completed)	16a. Dece (Give	edent's Usual Occupa skind of work done of DO NOT use retired	ation during most of w	orking	16b. Kind of	f Business/In	dustry
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shound M	-	19a. Informant's Name/Relationship (T		19b. Mail	ing Address (Street a					Code)
s 1 and 2 should be filed within 72 hr Heelih and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, tra Medical		Mr. Robert Kolar	ek / Son	816	Francis A	ve. Bal	timore, 1	arvla	nd 212	227
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leath certifica attending ph	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		75			23d.	Date of delive	эгу
death	Physician/Med	in the past 12 months?	1 Live birth 2 4 Pregnant at ti 9 Unknown		□Ectopic pregnancy □ Other (specify)				Month	Day Year
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	ပိ	25. Was case referred to medical				26 Place of D	1 ☐ Yes a	No	1 🗆 Yes	2 □ No
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ding Ph h. After th funeral	T:U	27. Manner of Death Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time (of 28c. Injury Work		28d. Describe ho			
eath. or: Al	catic	2 Accident investigation				Yes 2 □No				
or Att	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	y - Al home, farm, st (Specify)	reet, factory, office		28f. Location (St City or Town	reet and Nu , State)	mber or Rura	al Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifica completely filled in by the funeral director,	O	29a. Certifier Certifying Phy	sician: To the best of	my knowledge, dea	th occurred at the tim	ne, date and place	ce, and due to the ca	ause(s) and	manner as s	atated.
he Ho in 24 I he Fu pletely	edical	(Check only 2 Madical Examone)	inar: On the basis of e and manner state	examination and/or in	nvestigation, in my op	oinion, death occ	curred at the time, d	ate and plac	ce, and due to	the cause(s)
To 1 To 1	Σ	29b. Signature and title of certifier	VA		29c. License	number	2	9d. Date sig	ned (Month,	Day, Year)
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6		30. Name and address of person who c	win m	ath (Item 23a) (Type 0 3449	Wilkens	Ave	# 300 Ba	Inmor	ie M	2007
S Regis	tate trar	31. Date filed (Month, Day, Year) JUN 2 7 20	07 32 Aegistrar	's Signature	rede					

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July, MEDICAL POCTUR 30. Name and address of Gerson who completed cause of death (Item 23a) (Type, Print) 305E VARCAS, THE JOHNS HOPKINS HOSTITAL, GOONOPTH LOLFE STREET BAZIMINE, MARYLAND, State 31. Date filed (Month, Day, Year) 32. Pointra's Signature	3	equire en sig uld be	ed b	HYPERTEN	SIUN				1 🗆	Yes 2□N	lo 3 Prob	ably 4 □U	nknown
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July, MEDICAL POCTUR 30. Name and address of Gerson who completed cause of death (Item 23a) (Type, Print) 305E VARCAS, THE JOHNS HOPKINS HOSTITAL, GOONOPTH LOLPE STREET BAZIMINE, MARYLAND, State 31. Date filed (Month, Day, Year) 32. Pointra's Signature		After After funera	ion:	1 Natural 5 Pending	(Month, Day Year)				28d. Describe	how injury oc	curred		
July, MEDICAL POCTUR 30. Name and address of Gerson who completed cause of death (Item 23a) (Type, Print) 305E VARCAS, THE JOHNS HOPKINS HOSTITAL, GOONOPTH LOLPE STREET BAZIMINE, MARYLAND, State 31. Date filed (Month, Day, Year) 32. Pointra's Signature		death death ctor: y the	licat	3 Suicide 6 Could not be	28e. Place of injury - At hon	ne, farm, stre		163 2 110	28f. Location	(Street and N	umber or Rura	al Route Numi	be <i>r</i> .
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July, MEDICAL POCTUR 30. Name and address of Gerson who completed cause of death (Item 23a) (Type, Print) 305E VARCAS, THE JOHNS HOPKINS HOSTITAL, GOONOPTH LOLPE STREET BAZIMINE, MARYLAND, State 31. Date filed (Month, Day, Year) 32. Pointra's Signature	4	within To the complete complet	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date si	gned (Month,	Day, Year)	
30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 30. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Palestra's Signature		7		Jose Vins ME	OTCAL DOCTOR		REG	C-000		JUNE	23	2007	
State 31. Date filed (Month, Day, Year) 32. Palistra's Signature 32. Palistra's Signature	11)		30. Name and address of Jerson who con	npleted cause of death (Item)	23a) (Type, f	Print)			9	- /		21)8:
State 31. Date filed (Month, Day, rear) 32. Falls(rar's Signature	10			305E VARGAS, THE J	OHNS HOPKINS	H0517	TAL, 600	NORTH L	NULFE ST	LE ET, BAZ	JIMINE	MARYLAN	0,
Registrar JUN 2 7 2007				JUN 2 7 20	32. Penstrar's Signati	H A	rack i			•	·		•

Certificate of Death

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1	Fi	13	1	
L 100	\cup	U	-1	-

Physician
/Medical
Examiner

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036 Physician

/Medica Examine

Kemper, Frances

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funaral Director: A completely filled in by the fu

State

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month Day Year) 7

30. Name and address of person who completed Michael Crowley

	1. Decedent's Name (First, Middle, Last)	1 1/2	400	0				2. Date of Dea Month	th Day	Year	3. Time of Death	
ian ical	+RANC15	AKE	MPEI	2				06 21 2007			3:05p M	
ner	4a. Facility Name (If not institution, give s			4b. City,	c. City, Town, or Location of Death 4c.					4c. County of Death		
	The Pines Genes	is Health (Care]	East	on				ralbo	ot	
	Social Security Number 6. Sex		last birthday)	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birtl	Year)	9. Birthp	lace (State or Foreign	
	213 16 4849 11X	IM 2□F 87	Yrs.	WICHTHIS	Days	Hours	(VIII I.	May 31			vland	
	Usual Residence of Decedent											
	10a. State 10b. County		y, Town or Lo	cation						1	0d. Inside City Limits	
흕	Maryland Talbot	. E	Easton								1 ☐ Yes 2 🛣 No	
<u>ē</u>	10e. Street and Number			10f. Zij	p Code				l 0g. Citizen of	What Cour	itry?	
0	29353 Will Stree	et			21	601			U.S	U.S.A.		
Jer	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. \	Nas Dece	dent of H	ispanic Or	igin? (Spe	ecify Yes or No- Rican, etc.)		ce - Americ		
Ē	1 Never Married 2 Married	Armed Forces? 1 XYes 2 No	2 🗆 No				n, Puerto	Rican, etc.)		ack, White,		
þ	3 XWidowed 4 Divorced	If Yes, Give Year or Dates:		Yes	2 No	Specify:			Spec	ity: Whi	.te	
ted	15. Decedent's Educ	cation	16a. Deced	lent's Usu	al Occup	ation			16b. Kind of I	Business/Ind	dustry	
pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	NOT u	ork done o ise retired	during mos	t of work	ng				
E	12th	Conege (1-401 54)	Fin	re Fi	.ghte	r			Fire I	Depart	ment	
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)					18. Moth	er's Name	(First, Middle,	Maiden Suma	ime)		
To B	Frank	Kemper					athe	rine Eh	art			
-	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	q Address	s (Street a					n. State. Zip	Code)	
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Kemper / son 29353 Will Street Easton, Maryland 21601											
20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. L									20c. Location			
	1 Burial 2 Cremation 3 Re	emoval from State	semetery, cren 1y Cros				6/23	/2007			Maryland	
	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liceose		-									
	Luna N	~Amissle	shi 40	001 R	Ritch	ie Hi	y Go ghwa	nce Fun v Balt	eral Se imore,	ervice Maryl	e, P.A. and 21225	
	23a. Part1. Enter the disease, or complic	cations that caused the death								Ī	Approximate	
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition)										Interval Between Onset and Death	
	disease or condition resulting in death) Due to (or as a consequence of):										years	
		Dag 10 (0) ag a gg1130q	donos 017.	,-								
ē	Sequentially list conditions, if any, leading to immediate	Due to for as a conseq	ruenes of):									
cian/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
Exa	resulting in death) Last	Due to (or as a consequ	uence of):									
ie												
B	•			-								
N.	IF FEMALE:	3c. If yes, outcome of pregna	ancv						204.5			
ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐Fetal	I death 3	Ectopic p						ate of delive lonth	ory Day Year	
	1 □Yes 2 □ No 9 □ Unknown	4□Pregnant at time of de 9□Unknown	eath 5	Other (sp	овспу)							
P	Part II. Other significant conditions con	tributing to death but not resu	ulting in the ur	nderlying c	ralise div	an in Part I		23a Did to	hacco use cor	atribute to th	ne cause of death?	
5	Bladder tu			.do.ry mg c	January y.v.	J			es 2 □ No	3 Prob		
tec	1/2 1:00	7706							85 2 110	3,21,100	abiy 4 Gorikilowii	
ğ	Hemesinik							24a. Was a autop:		Were autor	psy findings available apletion of cause of	
Completed by Physi	Anemia							perfor	ried? 2 No	death?	2 🗆 No	
25. W ca e referred to medical examiner? 1												
									ence 6 Ot	her (Specify)	
	27. Manner of Death . Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	2	28c. Injury Work			28d. Describe h				
atic	2 Accident investigation	n M 1 ☐ Yes 2						2 No				
ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factor	y, office			28f. Location (Street and Number or Rural Route Number,				
e e	_	building, atc. (<i>Spacily)</i>						City or Town, State)				

Registrar

cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

610 Dutchmans Lane Easton MD 21601

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician 2:11 PM Paul Kluthe Ε. 25 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** N/A Union Memorial Hospital Baltimore City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1X M 2□F 78 332-20-6233 December 27.1928 Director New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 XYes 2 No Maryland N/A Baltimore, Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 911 W. Lake Avenue U.S.A. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify. Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 yr's College (1-4or 5+) other than 5+ yr's Roman Catholic Priest Church permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, it 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Kluthe Clara Tecklenburg 2 19a. Informant's Name/Relationship (Type. Print) Fellow Priest 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
St. Joseph Society Sacred Heart 1130 N. Calvert Street Baltimore. MD 212 1130 N. Calvert Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State 6/29/07 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Baltimore, MD 22. Name and Address of Facility Baltimore, Maryland 21. Signatur of Funeral Service Lice Inc. 5305 Harford Rd. <u>eonard J. Ruck,</u> 23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final Haemorhas **Physician** Intra Craminal disease or condition resulting in death) 5 days /Medical Examiner Hy Revtension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Mitral Valve diseau Due to (or as a consequence of) Examiner use as the burial-transit Coronary Or esydisease Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? res 22No 1☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: e Hospital or Attending F 24 hours after death. e Funeral Director: After 1 Natural 2 ☐ Accident (Month, Day Year, injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 ☐ Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the lewithin 2. 29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

zashar

Year)

31. Date filed (Month, Day,

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

Union Memorial Hospita

DHMH 17 Rev 1/2001

07-04774 Davon Lopez

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death Reg. No.									1 2010	
	Physician/ 1. Decedent's Name (First, Middle,Last)						Date of Death Month	Day Year		3. Time of Death		
Medical Examin		Da'Von			Lopez			J	une 22, 20	07		2342 hrs
	ľ	4a. Facility Name (if not institution, gi Franklin Square Hospital	ve street and number)			City, Towi	n, or Location of	f Death		4c. County of Baltimore		nty
Funeral	- 1	Social Security Number 6. S	Sex 7. Age	(In yrs. la		f Under 1			. Date of Birth	(MM/DD/YYYY)		
Director	Ļ		M 2 F	16	Yrs.	Months	Days Hours	Min.	6-23-1	.990	Foreign Cou	ntry) Md.
,	- 13- E	Usual Residence of Decedent 10a. State 10b. County	11	Oc City 7	Town or Location					12 6		10d. Inside City Limits
daryland 28a-f show any 1 at once.		Md. NA		,,	Baltim	ore		7.0			- 1	1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notiffed at once	Director	10e. Street and Number 8 Gamewell Garth	ו		1	Of. Zip Co 2]	^{de} 236		100	g. Citizen of What USA	at Count	ry?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	L	11. Marital Status 1 X Never Married 2 Marrie		ver in U.S X No			of Hispanic Orig uban, Mexican,			14. Race White		an Indian, Black,
after d	ā.		d If Yes, Give Year or Dates:				No specify:			Specify:		ack
5-0036 led within 72 hours afte thygiene "natural", other than "natural",	eted	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	only highest grade comp College (1-4 or 5+		16a. Decedent's during most		cupation (Give k g life. DO NOT i			16b. Kind of Bus	siness/In	dustrý
036 ithin 72 ne. r than	립	10th grade			Studen	t				NA		
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than e went, the Medica		17. Father's Name (First, Middle, Las		Г						aiden Surname)	Gas	ane.
2121 Id be f Mental narke event	o Be	David 19a. Informant's Name/Relationship (and the second second second	Lope:		idress /		geane		er, City or Towr	_	
nore, MD 2121 gges 1 and 2 should be fi nt of Health and Mental 1 i: If item 27 is marked other traumatic event,		Angeanette Lopez	Mother				Garth				2123	
ore, MD es 1 and 2 sho of Health and If item 27 is her traumati	Ī	20a. Method of Disposition 1 X Burial 2 Cremation 3	Removal from State	1	lace of Dispositio rematory or other	n (Name o			ate	20c. Location -		
Baltimore, permit. Pages 1 an Department of He Important: If ite		4 Donation 5 Other Specif	y:	1	rden of			6-30	0-07	Baltim	ore	
Baltimc permit. Page Department of Important: injury or ott		21. Signature of Funeral Service Lice					dress of Facility	Mar	ch F.H	. East more, M	7	21202
Physician	+	23a. Part I. Enter the disease, or com	plications that caused th		Do not enter the	node of d	ying, such as ca	ardiac or re	spiratory arres	st, shock, or hea	irt	Approximate Interval
/Medical	1		a. Gunshot wounds	of tors	0			7.590				Between Onset and Death
	1	or condition resulting in death)	Due to (or as a conseq	uence of)):							
Stant or	힐	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause	Due to (or as a conseq	juence of)):		77.7		100		-77	
	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of)):		-					
executed an and al - transi			!				•					
ੂ ਜ਼ੁਜ਼ੂ	edical	UNPENDED	X AMENDED #19a, perFH	,G868.	, 6/27/07	IΤ				T		
38760, rtificate be	<u>Ş</u> ;	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live birth	e or pregn	2 Fetal		3 Ectopic	pregnancy	,	23d. Date of Month		ay Year
n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be h. After this certificate has been signed by the attending physici inneral director, page 2 should be detached for use as the buri	Physiciar	1 Yes 2 No 9 Unknow	4 Pregnant at ti	me of dea	ath 5 Other	(Specify)						
P.O. Es that the gned by the e detached	면 무	Part II. Other significant conditions	contributing to death i	but not re	sulting in the und	erlying ca	use given in Pa	irt I.				he cause of death?
ords, P.C. w requires that us been signed to	ed led							-	1 Yes			opsy findings available
Corc law re has be	Completed								autops	у р		ompletion of cause of
tal Rectinn: The l	ខ្ញុំ	25. Was case referred to medical				00.1	Dinner of Death	(Ob l l	1 Y Yes 2	No1	✓ Yes	s 2 No
fital sician sician is cert	<u></u>	examiner?	Hospital:	1 2 🗸	ER/Outpatient 3		Other	Nursing F		Residence 6	Other:	
n of Vital ling Physician: After this certifi funeral director,	입	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	, 	28b. Time of Inju		. Injury at Work	? 28	d. Describe h	ow injury occurre		
ttendin death.	[흝	Natural 5 Pending Accident Investiga	FOUND: tion Jun 22, 2007	,	FOUND: 2225 hrs	1	Yes 2	No St	ıbject shot			
Division of Vital Records, tal or Attending Physician: The law requirers after death. The law rector: After this certificate has been similar in by the funeral director, page 2 should be in by the funeral director, page 2 should be in the funeral director.	Certification:	3 Suicide 6 Could no	t be 28e. Place of Inju			factory, of	fice building, et		or Town, Sta			al Route Number, City
hou hou		4 V Homicide	cian: To the best of my			at the tin	ne, date and pla	1				
Division To the Hospital or Attential within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		er: On the basis of exami and manner stated.									
FFF	ž	29b. Signature and title of certifier					cense number			29d. Date signe		th, Day, Year)
, 7		Cuox		-41- (1)	202).C.M.E.			June 23, 20	707	
3		 Name and address of person who Ana Rubio MD. Assista 	completed cause of deant Medical Exami		^{23a)} 111 Penn Str	eet, Bal	timore, MD	21201				
Sta	te	31. Date filed (Month Pay Year)	2007 32. Fegistrar's	s Signatur	1 Span	2						
Registr	eΠ	The second secon	The state of the state of	ALSE COL	1	-	_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar State 24a, 25, 26, 27 per dr. 18868, 06/27/07dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7:40 PM M June 8, 2007 Jane J. Love /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Adventist Hospital Montgomery Takoma Park Birthplace (State or Foreign Country) 5. Social Security Number Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔀 F Months Dec 2**9,** 1915 91 Illinois Director 360-05-8407 Usual Residence of Decedent is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Greenbelt Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the M-dical Examiner must be nother traumatic event, 20770 USA 3 D Plateau Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) artist/manicurist art/cosmotology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Stanley Don Hemphill Olive Ann Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Douglas Love/son 3 D Plateau Place Greenbelt, MD 20770 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Himportant: If ite any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Ronald S

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Rom 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final therusclerotic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner & YU harry Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed Sehr and Due to (or as a consequence of): P.O. Box 68760, been signed by the attending physician should be detached for use as the buria emenha Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate 2X No or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Division 1 Natural
2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)
JUN 2 7 2007

TAHMINA

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

06-09-07

AHMED MO

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	101	epartment of Health and N			
		Certificate of Death	Reg. No. 2	20703	
Physician	Decedent's Name (First, Middle, Last)		Date of Death Month Day Year	3. Time of Death	
/Medica	James Bernard Lo	ar, Sr.	June 25, 2007	4:56 A ^M	
Examine		4b. City, Town, or Location of Death	4c. County of Deal		
Funeral	Stella Maris Hospice Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Timonium nday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth 9. Birth	nore hplace (State or Foreign	
Funeral Director	NOW OF F	rs. Months Days Hours Min.	(Month, Day, Year) Co	cyland	
filed within 72 hours after death with the Maryland Hygiene. Whygiene. Wher than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits	
e Ma 3a-f s	Maryland Baltimore 10e. Street and Number	Fort F	loward	1 ☐ Yes 2 No	
vith the		10f. Zip Code	10g. Citizen of What Co		
r items 23a	7518 Blank Avenue 11. Marital Status 12. Was Decedent Ever in U.S.	21052	United Sta		
ter de	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 [XNo	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - Ame Black, Whit		
urs at	3 XWidowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify:	White	
72 ho natur lical	15. Decedent's Education 16a. I (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Business	Industry	
ithin ne.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years	(Give kind of work done during most of work life. DO NOT use retired)		_	
Hed w tygien the		Steamfitter	Industria	al	
ntal Hed ott			e (First, Middle, Maiden Surname) Bloucher		
hould Men marke		Mailing Address (Street and Number or Rus		Zin Code)	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		308 North Dakota Ave		21219	
of He	20a. Method of Disposition 20b. Place of cernetery 1 □ Burial 2 □ Cremation 3 □ Removal from State	Disposition (Name of , crematory or other place)	Date 20c. Location - City or	Town, State	
. Pag tment tant: I	4□Donation 5□Other (Specify) Hillto		3/2007 Towson, Ma	-	
permit Depar Impor any in	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Duda-Ruck Funeral 7922 Wise Ave Du	Home of Dundalk, indalk, Maryland 2		
SEE SEE	23a. Part1 Efter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.			Approximate Interval Between	
Physician	Immediate Cause (Final disease or condition RECTAL CANCER			Onset and Death	
/Medical Examiner	resulting in death) Due to (or as a consequence or	f):			
- 10 m	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence or	Α.			
executed in and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying that initiated events c	1).			
be executed sician and burial-transit	resulting in death) Last C Due to (or as a consequence or	f):			
4 2 5 0 1					
leath certificate I attending physic for use as the b	IF FEMALE:				
ath ce ttendi	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death	3 ☐ Ectopic pregnancy	23d. Date of de Month		
nat the death certifical do by the attending phy etached for use as the	1	5 ☐ Other (specify)	Worth	Day	
that the dended by the statement	ran ii. Outer siumiicant conunions continbuting to death but not resulting th	the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?	
uires n signe			1 Yes 2 No 3 P	robably 4 1 Unknown	
tw requir s been si shoutd I			24a. Was an 24b. Were a	utopsy findings available	
The law requi			autopsy prior to performed? death?	completion of cause of	
iclan: The certificate ector, pag		26. Place of Deat	1 Yes 2 No 1 Yes h (Check only one)	2 No	
Physic this ce al direc	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ EB/Out	patient 3 DOA Other: 4 Nursing Ho	me 5 Residence 6 NOther (Spe	cify) HOSPICE	
ding Ph h. After th funeral	OZ Manusa af Davids Douglas af Julius Look Wil		28d. Describe how injury occurred		
tendi eath. tor: A	2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No			
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	4 Homicide determined 28e. Place of injury - At home, fan building, etc. (Specify)	m, street, factory, office	28f. Location (Street and Number or Ri City or Town, State)	ural Route Number,	
spital ours a neral filled		death occurred at the time, date and place	and due to the cause(s) and manner a	e etatod	
the Hosp in 24 hou the Fune	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.	/or investigation, in my opinion, death occur	red at the time, date and place, and du	e to the cause(s)	
To the I	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mont	h, Day, Year)	
	1-	D 4372	1 6/25/	107	
10	30. Name and address of person who completed cause of death (Item 23a) (1	ype, Print)			
* (1)	DR. TARIQ MAHMOOD 2300 DULANEY VA		MD 21093		
ے State Registra	1111 0 W 0007 E 1 10 4	cali			

				in Black Indelible Ink. Ensure All Copies Are Legible.	
		•	1- State of Mary	yland / Department of Health and Mental Hygiene **Certificate of Death** **Reg. No. 2 0 0 7 2 0 7 1	
	5 , 5013		negistrar 1. Decedent's Name (First, Middle, Last)	2. Date of Death 3. Time of Death	1
5.6	Physici /Medic		ALEXANDER	LEBOVITS June 25 2007 2134	₽ M
	Examin Funeral Director		4a. Facility Name (If not institution, give street and number) 5. Social Security Number 6. Sex 194-30-7232 Usual Residence of Decedent	throse Bothyrore City N/A In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) N/A N/A 8. Date of Birth (Month, Day, Year) N/A 9. Birthplace (State or Fo Country) N/A N/A 10 Yrs. Months Days Hours Min. (Month, Day, Year) N/A 11 Year If Under 24 Hrs. (Month, Day, Year) N/A 12 Year Output N/A 13 Date of Birth (Month, Day, Year) N/A 14 Date of Birth (Month, Day, Year) N/A N/A N/A N/A N/A N/A N/A N/	oreign
	yland low at			0c. City, Town or Location 10d. Inside City Li	imits
	e Mar Ba-f sh rtified	ctor	MD N/A	BALTIMORE 1X Yes 2	□ No
	with the a or 2 the no	Dire	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	3701 GLEN AVENUE 11. Marital Status 1 □ Never Married 2 ◯ Married 3 □ Widowed 4 □ Divorced 1 □ Vez or Dates:	er in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.	
2-0	72 ho "natur dical I	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	
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	ould be filed Mental Hygid arked other atic event, the	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)	
Maryland	2 should the and Mental Is marked	욘	BERNAT 19a. Informant's Name/Relationship (Type. Print)	LEBOVITS GITEL STERN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Ma	and 2 sho ealth and n 27 Is ma		ALICE LEBOVITS / WIFE	3701 GLEN AVENUE -BALTIMORE, MD 21215	
Baltimore,	ges 1 and it of Health If Item 27 or other tr			20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State	
ţi.	Pa men ant: ury			HEARITH ISRAEL CONG. 06/26/2007 BALTIMORE, MD	
Bal	permit. Departr Imports any inj		Hall M. C. Hall	22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208	8
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	Approximate Interval Betwee Onset and Deat Consequence of): Approximate Interval Betwee Onset and Deat Consequence of Deat Conse	en
. Box 68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	pregnancy □ Fetal death 3□Ectopic pregnancy ■ Month Day Yeal	ar
P.0	at the d by the etache	Phys	9 ☐ Unknown Part II. Other significant conditions contributing to death but n	not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death	th?
	uires th signe Id be d	d by	Post-operative myocaro		
l Records,	The law require ate has been signage 2 should b	Completed by	Hypertrophic Obstruction	24a. Was an autopsy performed? Yes 2 No	ailable se of
Vital	slclan: certific rector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient	26. Place of Death (Check only one) Other: 4	
יסר	ig Physter this neral di	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of 28c. Injury at 28d. Describe how injury occurred	
Division or	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation	M 1 ☐ Yes 2 ☐ No At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number)	r,
	ne Hospita n 24 hours ne Funeral pletely filler	Medical C		my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ad.	
	To ti withi To ti comi	Ň	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)	
	, h		1 homas Genuit	MD JOOST 119 JUNE 24, 200	4
	10		30. Name and address of person who completed cause of death \$1 \times 100 \ti	RATULORES DIS DEPT SURGES LA	
- 1	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's	s Signature	

Kyle Lewis,
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** Amend #10e Per FHG868 (Pertificate of Death Reg. No 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day June 23, 2007 0427 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death University of Maryland Baltimore 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Months ·Hours Min. Days Director 220-17-402 Country) 1 V M 2 Usual Residence of Decedent any 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location or items 23a or 28a-f show must be notified at once. 1 Ves 2 A Himore permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she Injury or other traumatic event, the Medical Examiner must be notified at once. Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 206 N. Edgewood Street USA 21229 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married Yes 2 1 No If Yes, Give Year Yes 2 No specify: Widowed Divorced Specify: lac 2 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industri Completed Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 4/4 Inemployed 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be 2 W13 Dora ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Consu athanie R altimore md 21229 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 30 0 altimore Donation 5 Other Specify Signature of Funeral Service Trensee Alame and Address of Facility Cenc www.clsycs Battmar, MU 21229 Baltimore Nott Pine 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and Medical a. Multiple Gunshot Wounds Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions ner if any, leading to immediate Due to (or as a consequence of): causs. Enter U. denying Caus. Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 burst after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Inpatient 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 Other ۵ 1 🗸 Yes 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Certification: Subject shot Jun 23, 2007 0248 hrs 1 Yes 2 ✔ No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 1500 Pennsylvania Ave., Baltimore, Md. determined (Specify) Local Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) June 23, 2007 O.C.M.E Di 30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimpre, MD 21201 32 Registrar's Signature JUN 2 7 31. Date filed (Month State Registra

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			1 - For State Registrar	State of Maryland		nent of H			iene	7 20700	5	
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Last An Hoory 4a. Fecility Name (If not institution, give North Wast	undsay		City, Town, or	Location of Dear	2. Date of Deat Month	Day	Year 935 A	M	
	Funeral Director		5. Social Security Number 6. Se 216-88-6531	7. Age (In yrs. la		Inder 1 Year nths Days	If Under 24 Hrs Hours Min		1963	9. Birthplace (State or Foreign Mary and	gn	
036	is after death with the Maryland ", or items 23a or 28a-f show contror must be notified at	ector	Maryland Balti 10e. Street and Number		Town or Location				Og Citizen of Wi	10d. Inside City Limit 1 ☐ Yes 2 🕱 N		
	ath with a 23a or 3	Funeral Director	6740 Ransome			2	1207		United United	1 States		
	72 hours atter death with the Maryland natural', or itame 23a or 28a-i show ilsal Exzantiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:		2.4	ispanic Origin? (S in, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		- American Indian, k, White, etc. Black		
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Maryland	Mental Mental arked o	To Be (17. Father's Name (First, Middle, Last) Julius Linds				Anni	Name (First, Middle, Maiden Sumame) ie Witherspoon				
	alth a		19a. Informant's Name/Relationship (T) Theresa L. Roy:	ster-Sister	6740	Ranso	ome Dri	The second secon	timore,	Maryland 212	207	
Baltimore	mit. Pages 1 an andment of Heacortant: If item injury or other.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	COI	ace of Disposition metery, cremator Odlawn	Cemel	ery 6	2007	Baltin	city or Town, State More, Maryla		
Ball	permit. Pag Department important: eny injury o		21. Signature of Funeral Service Licens	Change Contract	P. O	· Box	VITTIAM 11651 E	s Funera Baltimor	1 Service, Mary	a P.A. sland 2122	9	
	Physician /Medical Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a							Approximate Interval Between Onset and Death	4		
8760,	death certificate be executed e attending physician and id for use as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Metastasic Livir Concer										
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	sign d be	þ	Part II. Other significant conditions col	ntributing to death but not resul	ting in the underly	ving cause give	en in Part I.			ouse contribute to the cause of death?		
Vital Records,	The ete h page	Completed						24a. Was ar autops perform 1 Yes 2	pr ned? de	vere autopsy findings available for to completion of cause of eath? □ Yes 2 No	ole f	
Zi Zi		o Be	25. Was case referred to medical examiner?	fospital: 1 ☐ Inpatient 2	R/Outpatient 3	DOA Othe	ar.	ath <i>Check onl</i> i on Home 5 ☐ Reside		r (Speciful)		
	ng Phys Iter this Ineral di	on: T	27. Manner of Death Natural 5 ☐ Pending	-	28b. Time of Injury	28c. Injury Work		28d. Describe ho				
Division	o the Hospital or Attending I ithin 24 hours after death. o the Funeral Director: After mpletely filled in by the funer	Certification:	Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, f		Yes 2 □ No	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	e Hospital 24 hours : Euneral letely filled	dical	29a. Certifier 1 Certifying Physical Control (Cineca Only One) 2 Medical Example (Cineca Example One)	sician: To the best of my know ner: On the basis of examination and manner stated.	ledge, death occi on and/or investig	rred at the tim ation, in my op	ne, date and place pinion, death occi	e, and due to the ca arred at the time, da	use(s) and man ite and place, ar	ner as stated. nd due to the cause(s)		
	To the within 2 To the cumpler	Me	29b. Signature and title of certifier	Pm.	1)	29c. License				(Month, Day, Year) 25th 200-	7	
	7		30. Name and address of person who co	empleted cause of reath (Item :	23a) (Type, Print)	10/1	of Cov.	rt. Ro	od R	25th 200- and all stow D 2113	50	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire to do	role)				0 2113	5	

			1_ For State	Type or Pri State of M		d / Depa	artme	nt of H		and Me	-	ygien	900	ole.	20707
			Registrar 1. Decedent's Name (First, Middle, Las	1)		Cei	unca	le or	Deam		2. Date of D	Reg. N	ö.		3. Time of Death
	Physici /Medic		Avgerinos D. 1	Mavrophil.	ipos						Month 6	25	ay D 2	Year	6:05 P M
	Examir		4a. Facility Name (If not institution, give	street and number;			4b. Cit	y, Town, o	Location o	of Death		4	c. County	of Death	4
	Α.,	18	GOOD SAMARIT 5. Social Security Number 6. Se		SPITA			ltimo	ore C						
	Funeral Director		,	ZIM SUE	87	ast birthday) Yrs.	Months		Hours	Min.	B. Date of B (Month, D April	Day Year	1920	Cour	place (State or Foreign htry) BBCB
the Maryland	28a-f show	Director	10a. State 10b. County Maryland Baltimo: 10e. Street and Number	re		, Town or Lo ЫSO∏		:- O-d-				10-0	'ai41a		0d. Inside City Limits 1 ☐ Yes 2 ☐ Yo
with	3a or		1 Smeton Place #	601				ip Code 11204				10g. C	itizen of W USA		ntry?
21215-0036 Within 72 hours after death with the Maryland	"natural", or items 23a or 28a-f show solical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces: 1 X Yes 2 I If Yes, Give Year or Dates:	,	S. 13.	Was Dec If Yes, sp		ispanic Origin, Mexican	gin? (Spec i, Puerto R	ify Yes or Nican, etc.)	lo-	14. Race	- Americ K, White,	ean Indian, etc. white
	than than	Completed b	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation	5+)	(Give	kind of w	rork done	ork done during most of working					16b. Kind of Business/Industry Restaurant	
₽ ₹	d oth	To Be Co	17. Father's Name (First, Middle, Last) Dimitrios A. May	vrophilip	os	CONTEL				er's Name (First, Middle, Maiden Sumame) ria Papazacharias					
	rages I and c rment of Health a rtant: If item 27 Is njury or other train		19a. Informant's Name/Relationship (7) Pari Mavrophilipos		100	1 Sme	ton	Place	#601	1 Τοω	Route Numi SON, N	dD :	21 204		
Baltimore,			20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Septice Licens)	Ce	ek Ort	natory or chode	other plac X Cei	neter	у	72007	Wo		ı⊓, M	laryland
g E	Depa Impo any ir		21. Signature of Porelail Secrice dicents	.00							κ ιοω: son, N			aı n 212	ome, Inc. N4
E:	ysician Medical caminer	Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	aCRITT (Due to (or as	ne. A L a consequ	AORTI ence of):				cardiac or	respiratory a	arrest,			Approximate Interval Between Onset and Death
od/ou, x	j physician and is the burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence of): d.											
Geath cer	y the attending physicia ached for use as the bur	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	to 12 months? 2 No 1 Leve birth 2 Fetal death 3 Lectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								The state of the s	23d. Date of delivery Month Day Year		,
ords, r	ate has been signed by the a page 2 should be detached	ted by P	Part II. Other significant conditions co									tobacco Yes 2	_	bute to th 3 ☐ Prob	e cause of death?
DIVISION OF VITAL RECORDS, P.O. To the Hospitet or Attending Physician: The law requires that the	icate has be r, page 2 sh	Completed				-					24a. Was auto perf 1 Yes		pr	or to cor	osy findings available npletion of cause of 2. No
VII	certificate irector, pag	Be c	25. Was case referred to medical examiner?	fospital:				On Othe			Check only				-
nding Phy	ath. r: After this e funeral d	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da	ry	R/Outpatien 28b. Time of Injury		28c. Injury Work	4 U Nui	28	dome 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			')	
Tet or Atta	within 24 hours after death. To tha Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At hor c. (Specify)	ne, farm, stre	et, facto	ry, office		28	f. Location (City or To			r or Rura	Route Number,
the Hospi	within 24 hours. To the Funeral completely filled	Medicai	29a. Certifier 1 Certifyin Phy (Check only one) 2 Medical Exami	sician: To the best ner: On the basis o and manner st	f examinati	rledge death on and/or inv	estigatio	n, in my op	data and pinion, deat	place and	diduia to the at the time.	daues(e , date an) and man d place, ar	ner at til nd due to	the cause(s)
To	To con	2	29b. Signature and title of certifier	110			29	c. License					ate signed		
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
10	Sta	te.	PRACHI JOG	GOOD S.	AMAI	RITAL	1 H	OSP	TAL	, B	ALTIN	MOR	E 1	MD:	21239
	Registr		31. Date filed (Month, Day, Year) JUN 2 7 200	7 Se. Registr	, D	Jes Day	36								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mildred 10:35 AM Mangle 200 uno /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Maryland Hosoital Jeneral 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Dec. 25, 1921 North Carolina Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Hours 1 M 3 F 247-30-0915 85 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location MD Baltimore Baltimore 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Meralt Hygiene.

Department of Health and Meralt Hygiene.

The most part of the Trian Meralt of the Trian "natural", or items 23a or items any injury or other traumatic event, the Medical Examiner must be rany injury or other traumatic event, the Medical Examiner must be rany injury or other traumatic event, the Medical Examiner must be rank injury or other traumatic event, the Medical Examiner must be rank injury or other traumatic event, the Medical Examiner must be rank injury or other traumatic event, the Medical Examiner must be rank injury or other traumatic event. 110 North Central Ave. 21202 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) self-employed House Keeper 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (David Richardson 2 Sallie Richardson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Mitchell 5756 Maplehill Road Baltimore MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 6/26/07 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation S ☐ Other (Specify) Baltimore MD price Licens 21. Signature 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral HOme of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner eromio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Colon Cancer led by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed rector, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 | Yes 2 | No 3 | Probably 4 | Onknown arture 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1□ Yes To the Hospital or Attending Physician: filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 21100 1 Impatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To after death. Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of who completed cause of death (Item 23a) (Type, Print) Maryland ian M.D. labataba 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year George R. Martin 23:35 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Kosedale Baltimore ranklin Square Hospital Social Security Number V 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** July 22, 1945 1**▼** M 2 ☐ F Months Days Hours 61 218-42-4969 Director Usual Residence of Decedent 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Baltimore Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 66 Admiral Blvd 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Service Rep Construction 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John MArtin Thelma Wright ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John MArtin /son 66 Admiral Blvd. Baltimore MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 Removal from State Bayveiw Crematory 6/26/07 Baltimore MD S ☐ Other (Specify) Syrvice Ucensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Phy /N Exa

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

	Immediate Cause (Final disease or condition resulting in death)	a. Due to (r s a consequence of):				Onset and Deat						
cal Examiner	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury lat initiated events esulting in death) Last b											
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Month									
	Part II. Other significant conditions	arificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the sum of the underlying cause given in Part I.										
Completed				24a. Was an autopsy performed?	prior to c death?	topsy findings avall completion of cause 2 No						
Be	25. Was case referred to medical examiner?		26. Place of Death (Check only one)									
ြို	1 □ Yes 2 No	Hospital: Nation 2 ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Hor	me 5 Residence	6 □Other (Spec	cify)						
	27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury N	28c. Injury at Work?	28d. Describe how in								
Certification:	3 Suicide 6 Could not b 4 Homicide determined											
Medical	29a. Certifier (Check only one) 1 Certifying Property 2 Medical Example 1	ysician: To the best of my knowledge, death occ niner: On the basis of examination and/or investion and manner stated.	urred at the time, date and place, gation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as and place, and due	stated. to the cause(s)						
Σ	29b. Signature and title of certifier	2 . 1	29c. License number	29d. D	ate signed (Month	ı, Day, Year)						
	1 Kan +1 (//	CII PID	RES KODAD		6/2 5/A	7						

Registrar DHMH 17 Rev 1/2001

State

Dr. Kenneth

31. Date filed (Month, Day, Year)

within 24

cause of death (Item 23a) (Type, Print)

9000 Frank

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Margaret 6:30 AM 07 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Renaissance Gardens Catonsville Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days 1 M 2 XF Months Hours Min 216-30-7438 Director 97 May 26, 1910 Maryland Usual Residence of Decedent 10h. County 10c. City, Town or Location 23a or 28a-f show 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 No Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane 213B 21228 United States Funeral items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 'natural", or 1 ☐ Yes 21☑ No þ Specify: White Specify: 3X Widowed 4 ☐ Divorced er than "natura the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker 7 is marked other traumatic event, the Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph J. McCart Barbara Reinhart ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Mills, Jr. / Son 11822 Ivy Mill Road, Reisterstown, Maryland 21136 Department of Health Important: If item 27 any Injury or other tr 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/28/07 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician End-Stage Dementio /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1∏ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, physician the the þ certificate has funeral director, this After

filed within 72 hours after

Hygiene.

Pages 1 and 2 should be nent of Health and Mental

Baltimore, Maryland 21215-0036

Hospital or Attending within 24 hours after death To the Funeral Director: filled in by the

nse for signed t I be deta page 2 should

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

State Registrar

711 Deneen Bowlin

カイイ377

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

ice

Lune, Catonsville, MD 21228

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Maiden

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death McDaniels Day **Physician** Month Year Ralph 1840 /Medical 24 7.007 4a. Facility Name (If not institution, give stre t and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore LOCHERA DUISING HUME Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 12 M 2□ F Days 75 2877 73 Yrs. Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at kes ville Director 1 □Yes ≥ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA or items 23a woup 21208 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

18 Yes 2 No 1954

19 Yes, Give Year or Dates: / 956 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or iten Black, White, etc. 1 Never Married Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ ★ o Specify Skek Specify: ' 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GINGER 4EAVS ABATULIEN 46ARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည 19a. Informant's Narpa/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOYLCLOUD dur CARD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any injury or ot Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State Signature of Euperal Service Licens Reis TErston BAI 23a. Part1. Enter the d'in ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock in heart fullure. List only one cause on each line. Approximate Interval Between Onset and Death nate Cause (Final Physician Atheroscherotic disease or condition resulting in death) ravs /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transi and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician the death certificate be Physician/Medical as the IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the detached 9 Unknown 9 Unknown 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Jnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1□ Yes 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 2D No P 1 Tyes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After opmpletely filled in by the funeral Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who complete

Zibell

MO

22

St.

cause of death (Item 23a) (Type, Print)

Main

Registrar's Signature

29c. License number

037573

29d. Date signed (Month, Day, Year)

21136

June 25, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner REHABILITATION EXTEN CA If Under 1 Year | If Under 24 Hrs Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F Davs Hours 68 235 62 8047 Virginia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 3a or 28a-f show t be notified at 10d. Inside City Limits Maryland Anne Arundel Baltimore 1 ☐ Yes 2 TN No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Camrose Avenue 21225 U.S.A. an "natural", or items 23a Medical Examiner must t Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White þ 3 AWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) 11th College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other that any injury or other traumatic event, the Agence. Truck Driver Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jay Lee Marsh Doris Arlene Broadwell မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Puryear / Daughter 103 Camrose Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 6/22/2007 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signalon, of F neral Service Like 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** AMOUS Due t (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown signed the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an ate has b page 2 s autopsy performed? Yes 2 No certificate 1□ Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

State Registrar

JUN 2 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22. Registrar's Signature

			1 - For State Registrar	State of Man		artment o			al Hygien Reg. N	400	7 20713
	Physici	an	1. Decedent's Name (First, Middle, Last	,					ate of Death	ay . Ye	3. Time of Death
	/Media			er Martin				5	nna	19,21	007 W:1514M
1	Examir	er	4a. Facility Name (If not institution, give Baltimore Washin		1 Contor	4b. City, Tow	n, or Location of	of Death	24 .	c. County of E	
	Funeral Director		Social Security Number 6. Se		n yrs. last birthday)	If Under 1 Ye Months Da			ite of Birth	9	Birthplace (State or Foreign Country) Centucky
	ס		Usual Residence of Decedent					Ju	ne 10,	1945 1	кепсиску
	anylan show	_	10a. State 10b. County		Oc. City, Town or Lo						10d. Inside City Limits
	he M.	Director	Maryland Anne	Arundel	Glen Bu						1 Yes 2 No
	With Ba or	ă	1414 Gordon Dri	VA		10f. Zip Cod	e 21061		10g. C	itizen of What	-
	death	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.			igin? (Specify Y	es or No-	U.S.A	merican Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural, or items 23e or 28e-f show spiritury or other traumatic event, the Madical Exaction Line Item Indiffice at ODE.	þ	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 Yes, specify 0 1 □ Yes 2 😾			etc.)		White, etc. White
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Maryland	2 short		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailir	ng Address (Stre			e Number, City	or Town, Stat	e, Zip Code)
≥,	and lealth m 27 her tr		Jacqueline Yate			Geis C					and 21061
Jore	iges 1 or of H or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	ľ		natory or other i	olace)	Date			or Town, State
Baltimore,	iit. Pa artmer ortant injury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	99	Bayview	Cremato: Name and Ad					, Maryland
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		00 33	23a Part1. Enter the disease or complishock, or heart failure List only o	ications that caused the ne cause on each line.	death. Do not ent				iratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	1	127	Con	cer				Strock and Double
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587	physics the Is	dlcal		d							
X	n certi	N/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p						23d. Date of	delivery
P.O. Box	The law requires thet the death certificate has been signed by the ettending bage 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		Ectopic pregna Other (specify)				Month	Day Year
ď.	ss thet	by Pi	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the ur	nderlying cause	given in Part I.	2:	Be. Did tobacco	use contribute	to the cause of death?
Records,	w require been sig								17 Yes 2	2□No 3□	Probably 4 □Unknown
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<u>~</u>	: The lav	S						10	performed? ☐ Yes 2 No	death o 1 ☐ Y	?
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Division of Vital	l or Atte efter de Directo i in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Ptace of Injury - building, etc. (S	At home, farm, stre	eet, factory, office	Ce C	28f. Lo	cation (Street a y or Town, Stat	nd Number or e)	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours alter death. To the Funerel Director: After this certifica completely filled in by the funeral director.	edical C	Conoch of the Land Can Cantain	sician: To the best of m	amination and/or inv	occurred at the	time, date and y opinion, deat	d place, and duth occurred at the	e to the cause(s	s) and manner	as stated.
	othe othe omple	Med	29b. Signature and title of certifier	and manner stated.			ense number				onth, Day, Year)
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	6	ŀ	30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, I	Print)	3 ,	AL	1	11/1/	Co took
			31. Date filed (Month Pay Year)	12. Registrar's	Signature #	try.	ital	Dr, c	7/20	RNL	me, with
	Sta Registra		JUN'2 7 200	7 Lines	Signature Sport	RED.		,			

Walter Markin

ORIGINAL

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1x 68/60, /	certificate be executed	ding physician and se as the burial-transit

Records, P.O.

Division or Vital

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 2:05 PM BENJAMIN NEEDLEMAN 2007 /Medical June 24 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospital Sina of Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F 213-12-4391 86 09/20/1920 Director MD Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits fshow the Medical Examiner must be notified at ¹ TYes 2 No MD N/A BALTIMORE 28a-f 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 4260 LABYRINTH ROAD "natural", or items 23a 21215 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Xes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) POSTAL EMPLOYEE **POSTAL** and Mental Hygi is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic ev WILLIAM NEEDLEMAN SARAH UNKNOWN 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRAD HARANSKY / NEPHEW 5550 COLUMBIA PIKE #1002 - ARLINGTON, VA.22204 20b. Place of Disposition (Name of cemetery, crematory or other place)
OHEL YAAKOV
BETH ISRAEL 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 06/26/2007 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Matt Le. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Intracranial week Due to (or as a consequence of): Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 10 as Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death ned by the attend detached for us 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 2**X**No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral! 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 1 XNatural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sina Hospital of Baltimore, 2401 w Belvedere Ave, 31. Date filed (Month, Day, Year) State JUN 2 7 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

/Medical **Examiner** or Vital Records, P.O. Box 68760, the attending physician CATHERINE O'NEILI

burial-tran the use as After this certificate Division To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft

Funeral

Director

"natural", or items 23a or 28a-f sh idical Examiner must be notified

with the Maryland

Baltimore, Maryland 21215-0036

Pages 1

Physician

Completed by Certification: To Be 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 2 Medical €

State

29b. Signature and title of certifier

JUN 2

DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 2007 OVERBECK JUNE ALLEN 24 6:35 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death RUXTON PIKESVILLE NURSING HOME PIKESVILLE
If Under 1 Year If Under 24 Hrs. BALTIMORE 8. Date of Birth 05/26/1941 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X** M 2□ F Days Months Hours Min 220-40-1619 66 MD Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE 1 ☐ Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 CLIFTON COURT 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ PEDIATRIC DENTIST DENTISTRY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) OVERBECK HAROLD IDA SATOSKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRIET OVERBECK / WIFE 2 CLIFTON COURT - BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State
'4 □ Donation 5 □ Other (Specify) BETH EL MEMORIAL PARK 06/26/2007 RANDALLSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 with 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Body Lewy Dementi years Due to (or as a consequence of): Parkinson's 40013 Caquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' 2 200 1 Yes 1 Yes 26. Place of Death Check onl one examiner? Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X ursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation M 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Pnysician /Medical Examiner the death certificate be executed use as the burial-transit Division of Vital Records, P.O. Box 68760. the attending physician hed for use as the burial Physician/Medical cate has been signed by i page 2 should be detach þ Completed this certificate has been Hospital or Attending Pl
 24 hours after death.
 Funeral Director: After ti Certification: To the Hospital of within 24 hours at To the Funeral D Medical

Physician

/Medical

Examiner

Funeral

Director

Item 271s marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examinal must be notified at

pernit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iter any injury or other traumatic event, the Madical Exertines any since

Baltimore. Maryland 21215-0036

by Funeral Director

Completed

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with the Maryland

death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 27. Manner of Death 1 Natural 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

completely

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jason Black, 6565 North Charles ST, Suite 209, Towson

29c. License number 00061199 29d. Date signed (Month, Day, Year)

June, 25, 2007

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year able 25 June 1815 /Medical 2007 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HOSPita land altimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 Ø F Days Hours 214-16-9865 Director lary Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location • how 10d. Inside City Limits item 27 is marked other than "natural", or itame 23a or 28e-f eho: other treumatic event. I'm Modical Examinar must be notified at Baltimore Director 1 ₽Yes 2 No 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 102 U.S. A. 601 2120 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 10 Specify: Completed by 3 Nidowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hyglene. Importent: If Item 27 is marked other than "eny injury or other treumatic event, Ina Ma. once. Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed withinent of Health and Mental Hygiene ouse Kieper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Royte Number, City or Town, State, Zip Code) Jud. 21201 apt 102 Bath Son oung 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐Donation 5 ☐ Other (Specify) 2007 21. Signature of Funeral Service Licensee Doing lass hou Bulto. 21207 Service P.A. 23a. Part1. Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Pertenson Due to (of as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien for use as the buria IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy 1 ☐ Yes 2 GNO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 ☑ No 1 tmpatient 2 ER/Outpatient 3 DOA hours after death. Inerel Director; After this y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 1 Contitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

JUN 2 7 2007

Mohammed

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a); (Type, Print)

aVU

32 Registrar's Signature

ORIGINAL

Z5, ZW7

Physician
/Medical
Examiner
LAGITITIO

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if lem 27 is marked other than "natural", or Itams ??----- any injury or other traumatic

Director

by Funerai

Completed

Physician /Medical Examiner

> Physician/Medical Examiner burial-transit attending physician for use as the the detached q signed t δ 99 page 2 should Be Completed been certificate has filled in by the funeral director. Certification: To this After within 24 hours after death. To the Funeral Director: A

The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

To the Hospital or Attending Physician:

For Stata Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death June Helen A. Peters 2007 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Genesis Franklin Woods Baltimore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 26, 1913 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)_ 1□M 2\ F 93 219-16-6389 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County MD Baltimore MIddle River 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10316 Bird River Road 21220 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates: 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home 8th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Daniel Edell Matilda Kimmerline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Muller /daughter 10316 Bird River Road Balto. MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 6/23/07 Baltimore MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave.Balto. MD art1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Connelly Funeral HOme of Essex_ not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence Sequentially list conditions, if any, leading to immediate the base of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 2 🗌 No

25. Was case referred to medical

5 Pending

investigation 6 Could not be determined

2/2 No

Hospital: 1 | Inpatient

28a. Date of Injury (Month, Day Year)

23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ hknown

24a. Was an autopsy performed 1 ☐ Yes 2 ☐ 🗗 24b. Were autopsy findings available prior to completion of cause of death? 2 □ No 1 ☐ Yes

21061

Day

Approximate

3. Time of Death

8:15p M

1 ☐ Yes 3 € No

26. Place of Death (Check only one) Other. 4 ursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

4 T Homicide 29a. Certifier

examiner

1 🗌 Yes

27. Manner of Death

2 ☐ Accident

3 🗌 Suicide

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

1 Tyes

2 🗌 No

29b. Signature and title certifie

ND

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address MD

Jude Muhreres JN 2 7 31 Date filed (Month



State Registrar

completely

7

Medicai

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Allison Elaine Paige ZE PM 24 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY SINAL HOSPITAL OF BACTHURE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 10, 1959 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 XX MD Director 217-68-0113 47 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show must be notified at Baltimore Director 1 XYes 2 No MD 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21223 USA 1628 W. Lexington Street 'natural', or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married SpecifyAfrican American 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 A Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within and Mental Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) dietary aide N.M. Carroll Manor 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland Be Aloma Paige Kenneth Single ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1628 W. Lexington Street; Baltimore, MD 21223 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Tyree Paige / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Holly Hills Cemetery 06/29/2007 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home, P.A. 21. Signature of Funeral Service Licens 22. Name and Address of Facility 638 N. Gilmor Street; Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence f): Examiner 12-87 S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (r as a consequence of): Examine certificate be executed ulumonia physician and s the burial-tran Due to (or as a consequence of): Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? for Month Vear Day 4□Pregnant at time of death 5 ☐ Other (specify) 0 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a Was an page 2 autopsy perform DIC Vital 1 Yes 2 No in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No Hospital: 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 9 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manyier of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director; 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a

To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 JUNE 24, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAL HOSPITAL OF WIBERG WIELL MO

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 2 7 2007

128

Registrar's Signature

Melquisades Sales Perdomo 07-04628 Plea Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day June 17, 2007 0957 hrs **Medical Examiner** se ec 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Franklin Square Hospital Rosedale **Baltimore County** 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** reign Hondurgs oreign Months Days Hours Min Director 0-21-1 X M 2 5 KNOWN Yrs Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 1 Yes 2 No 28a-f show death with the Maryland Director 10g. Citizen of What Country? items 23a or Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Never Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 2 Yes rmit. Pages 1 and 2 should be filed within 72 hours after opartment of Health and Mental Hygiene.
portant: If item 27 is marked other than "natural", o Yes 2 No specify: Widowed f Yes. Give Year Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 's Name (First, Middle, Maiden å 19b. Mailing Address (Street and Number or Rural Route Number, City or tant: If item 27 is or other traumatic 20b Place of Disposition (Name of cemetery crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 Other Specify: permit. 21 Signature of Funeral Service Licenses 3000 E Baltin 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or failure. List only one cause on each line. Approximate Interval Physician Between Onset and /Medical Death Cardiac arrhythmia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical X UNPENDED signed by the attending physician be detached for use as the burial AMENDED #23a.27.perME.g870.8/13/07 TI Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital the Hospital or Attending Physician: Be Other₄ examiner? Hospital: Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 After this ပ 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Director: Yes 2 24 hours after death. Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined Fo the Funeral Homicide 4 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within ? 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 18, 2007 O.C.M.E Dearse hno 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Melissa Brassell, MD Assistant Medical Examiner

DHMH 17 Rev 1/2001 OCME 2006

Registrar

IIIN

31. Date filed (Month, Day, Year)

OCME

ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2007 Year **Physician** Helen 23 G. Redden June 1:45am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ivy Hall Nursing Center MIddle River Baltimore 8. Date of Birth Jan . 16 , 1938 If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 234-58-1021 1 □ M 2/C)4F West Virginia 69 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits notified at MD Baltimore MIddle River 1 ☐ Yes 2 X No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be i 1536 Dornton Ave. 21220 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: White ģ 3 AWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Martin Marietta Inspector 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Ripley Viola M. Hinkle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denver King / son H-C 83 Box 279 Rainelle West Virginia 25962 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of F Important: If Ite any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 6/25/07 Baltimore MD 4 ☐ Benation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. 21. Signature of Funeral Service License Balto. Connelly Funeral Home of Essex 21221 23a. Part Enter the disease, or cook tin-trons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ne cause on each line. Immediate Cause (Final ARGE CELL **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be execute burial-tra attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performe 1∐ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ၉ 1 Dippatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 10 ause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760

			For State (State Registrar	of Maryland /	-	artment of Hertificate of E		d Mental Hy	/giene Reg. No.	07	207	23
	Di		1. Decedent's Name (First, Middle, Last)					2. Date of D Month	eath Day	Year	3. Time of	Death
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	Examin	er	4a. Facility Name (If not institution, give street and no	ımber)		4b. City, Town, or			4c. County of Death			
_			Holy Cross Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. last I	hirthday)	Silver	Spring			gomer	y place (State or	r Foreign
	Funeral Director		218-05-0514 1 ³ ★ ^M ² □F	91	Yrs.	Months Days		Min. (Month, D June 6	ay, Year)	Coul	ntry)	7 Greigh
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	with the	Funeral Director	10e. Street and Number 18549 Queen Elizabeth Dr	ri ve		10f. Zip Code 208	38		United		,	
	ne 23	erai		cedent Ever in U.S.	13. \	Was Decedent of His f Yes, specify Cubar		? (Specify Yes or N		14. Race - American Indian,		
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ဗ္ဗ	ours.	d by	3 X Widowed 4 □ Divorced If Yes, G Year or	Dates:		1 ☐ Yes 2 ☑ No	Specify:		Spec		hite	
21215-0036	within 72 hours after deeth with the Maryland ene. Then "neturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed		(Give	dent's Usual Occupa kind of work done d DO NOT use retired)	uring most of	f working	16b. Kind of	Business/In	dustry	
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Maryland	wild by Menta Menta arked	ToE	Edward Riley				Mat	tie Harri	s			
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			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	each line.					arrest,		Approximate Interval Betwood Onset and D	ween
	Pnysician /Medical		resulting in death)	onic Obstru		ve Pulmona	ary Di	sease				
	Examiner			(or as a consequenc	:e or):							
		ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying	(or as a consequenc	.5 Oi).							
/	icate be executed physicien and s the burial-transit	Examiner	that initiated events c.	,								
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X	nding use a	/We		utcome of pregnancy					23d. (23d. Date of delivery		
P.O. Box	The law requires that the deeth certifica site has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	1 Yes 2 No 4 Prec	birth 2 Fetal dea gnant at time of death		Ectopic pregnancy Other (specify)			1	M <i>on</i> th	Day Y	/ear
<u>Ф</u>	at the d by th etach	Phys	9 Unknown					on- Did			(KI)	
Š,	signed		Part II. Other significant conditions contributing to	death but not resulting	g in the u	nderrying cause give	m in Part I.	11	Yes 2 □ No	acco use contribute to the cause of death? 2 No 3 Probably 4 Munknown		
Sor	w requir been si should	Completed	2						1		opsy findings a	- 10-
Records,	he lav	d Li						— aut	opsy formed?	prior to co death?	mpletion of ca	ause of
Vital	ifficett		25. Was case referred to medical				26 Place of	1 ☐ Yes Death (Check only	2 No	1 🗆 Yes	21 No	
≥	ysicii is cer direct	To Be	examiner?	Inpatient 2 ☐ ER/	Outpatier	nt 3 DOA Cthe	or.	ing Home 5 ☐ Re		Other (Speci	fy)	
0	Attending Physician: The lav r death. ector: Atter this certificate hes by the funeral director, page 2		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date (Mo	of Injury 28t nth, Day Year)	. Time of	28c. Injury Work	at ?	28d. Describe	how injury occ	urred		
sio	tendi Jeath. tor: A the fu	cati	2 Accident investigation				/es 2 □No		/Ch		10- 1- 11-	
Division of	after of Direction by	Certification:	determined 200. Plat	ce of Injury - At home, ding, etc. (Specify)	tarm, str	eet, factory, office			(Street and Nui own, State)	mber or Hur	a <i>i Houte Nu</i> m	ber,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	29a. Certifier (Check only one) 1 Cartifying Physician: To the 2 Medical Examiner: On the and ma	ne best of my knowled basis of examination nner stated.	ige, deati and/or in	h occurred at the tim vestigation, in my op	e, date and pointion, death	place, and due to the occurred at the time	e cause(s) and b, date and place	manner as s e, and due t	stated. o the cause(s)
	To the within To the comp	Ž	29b. Signature and title of certifier	2 6		29c. License			29d. Date sig			
	_		I Walnut dolver	Do		M0064	4588		June 2	5, 200)/	
	10		30. Name and address of person who completed can	•			o C	- MD 00	010			
	Sta	ite	Dr. Asmish Tolia, 1500 F 31 Date filed (Month, Day, Year) 32	Registrar's Signature			Spr1	ug, MD 20	310			
	Registr		JUN 2 7 2007	mus &	And the	entil						

DHMH 17 Rev 1/2001

ORIGINAL

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8.0 8.0			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	illicate of L	eaui	2. Date of D	Reg. No.	.007	3. Time of Death
7507 au	ysicia		Johnora	Ross				Month June 2	Day	Year	8:30 AM ^M
	Medic kamin		4a. Facility Name (If not institution, give street			4b. City, Town, or I	Location of Death			County of Death	0.50 AM
			312 Swan Creek Rd.			Ft. Washi			Pr	ince Geo	orge
	neral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, D	ay, Year)	Coun	
Dire	ector	1	246-32-9118 1 M	2 X 81	113.			Jan 20	, 192	6 North	Carolina
yland	te		10a. State 10b. County	10c. City, Town	or Loc	eation				1	0d. Inside City Limits
Mar Mar	Iffled	cto	MD Prince Geo:	rge Ft. Was	hin	gton					1 □Yes 2Ã No
ith the	ou ac	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Coun	try?
ath w	nust		312 Swan Creek Road		140.14	20744			USA	A Daga Amaria	- 1- 1
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or items 23a or 28a-f show	iner n	Funeral	Tr. Markar Olatao	Was Decedent Ever in U.S. Armed Forces? I □Yes 2□LNo	13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (S i, Mexican, Puerl	pecity Yes or Note to Rican, etc.)	0-	4. Race - Americ Black, White,	
036 urs af al': or	xam	þ	3 ☐ Widowed 4 🕅 Divorced	l	1	☐ Yes 2 X No	Specify:			Specify: B1	.ack
5-0036 72 hours af	lical	Completed	15. Decedent's Education (Specify only highest grade co			ent's Usual Occupa		rkina	16b. Kir	nd of Business/Ind	dustry
2121 ed within /glene.	e Mec	mple		College (1-4or 5+)		kind of work done du OO NOT use retired)	ang most of tro	ning .			
filed w	f, E	ပိ	17. Father's Name (First, Middle, Last)	2 D1	eti	cian	18. Mother's Nan	ne (First Middle	· · · · · · · · · · · · · · · · · · ·	pital Surname)	
d be tental	c eve	To Be	Sylvester Ross				Cora Mo		, maidon	ourname)	
Maryland of 2 should be file th and Mental Hy 77 is marked oth	other traumatic event, the Medical Examiner must be notfilled at	F	19a. Informant's Name/Relationship (Type.	Print) 19b.	Mailing	g Address (Street ar			er, City or	Town, State, Zip	Code)
e, Marina 1 and 2 Health a	er tra		Cora A. Walker - da	0	2 S	wan Creek	Rd. Ft	. Washi	ngton	, MD 207	44
0 0 -	. h		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo	20b. Place of cemeter	Dispos y, crem	sition (Name of natory or other place)	Date	20c. Loc	cation - City or To	wn, State
Baltimor permit. Pages Department of	any injury o		4 Domation 5 ☐ Other (Specify)			Cemetery				ston-Sal	
Balt permit. Departr Imports	iny in		21. Signature of Funeral Service Licens e	11	22.	Name and Address					
	10 01		23a. Part1. Enter the disease, or complicati	Maure one that caused the death Don	ot ente					Winston-	Salem, NC
Dhuei	alon I		shock, or heart failure. List only one c Immediate Cause (Final	ause on each line.				114			Approximate Interval Between Onset and Death
Physi- /Med	-		disease or condition resulting in death)	Du to (or as a consequence o	of):	oncon	MOU	num	Ceur	AIC	YEALI
Exam	iner		Convention list conditions	`	,						/
pe	sit	Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	آل).						
xecut	ıl-tran	хаш	that initiated events resulting in death) Last	Due to (or as a consequence o	of):						
Hecords, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and	the burial-transit	lical	d								
58 tificate								-			
Box eath cert	for use as th	Physician/Med	23b. Was decedent pregnant	f yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death	3□	Ectopic pregnancy			2	3d. Date of delive	•
D. E le dea the att	tached fo	sici	1 Vee 2 Value	4□Pregnant at time of death 9□Unknown		Other (specify)				Month	Day Year
hat the	detach		Part II. Other significant conditions contrib	iting to death but not resulting in	the un	derlying cause giver	n in Part I	23e. Did	tobacco us	se contribute to th	ne cause of death?
VITAI KECOLDS, sician: The law requires t certificate has been signe	ld be det	d b				,g 3			3	No 3 □ Prob	
w req	should b	Completed						24a. Was	an 🐔	24b Were auto	psy findings available
The la	irector, page 2 s	omp						auto perf	psy ormed?	prior to cor death?	npletion of cause of
	tor, p	Be C	25. Was case referred to medical				26. Place of Dea	1 Yes ath (Check only	one)	1 ∐Yes	2□ No
Or V Physic rthis ce	0	일	examiner? 1 Yes 2 No Hosp	^{ital:} 1 □ Inpatient 2 □ ER/Out	tpatient	3 □ DOA Other	4 ☐ Nursing H	lome 5/3	idence 6	□Other (Specif)	1)
Ing P			1 Natural 5 ☐ Pending		ime of njury	28c. Injury Work?		28d. Describe	how injury	occurred	
DIVISION of Attending after death. Director: Afte	, the f	cati	2 Accident investigation 3 Suicide 6 Could not be	8e. Place of injury - At home, far	m etro		es 2 □ No	096 Leaption	Cimai a	Alumba v a v Dive	I Davida Alizantian
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certific	d in by	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	iii, sue	et, factory, office			wn, State)	l Number or Rura	i Houle Number,
spita hours neral	y filled		29a. Certifier Certifying Physicia	n: To the best of my knowledge,	, death	occurred at the time	e, date and place	l e, and due to the	cause(s)	and manner as st	ated.
he Ho in 24 he Fu	pletel	Medical	(Check only 2 Medical Examiner:	On the basis of examination and and manner stated.	d/or inv	estigation, in my op	inion, death occu	urred at the time	, date and	place, and due to	the cause(s)
To To To	등	Σ	29b. Signature and title of certifier			729c. License	number		29d. Date	e signed (Month,	Day, Year)
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						1)11	771		C.	140)	
	5		30. Name and address of person-who compl	eted cause of death (Item 23a) (Type, F	Print)	721 144 11B	FI.1L	Bolow	976) wi	20144
	Stat	te	30. Name and address of person-who complete the complete that the	eted cause of death (Item 23a) (Type, F	Print)	7-1 12#/18	Frech	Alv	9/00 kg	20144

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	State of Maryland / Department of Health and Mental Hyglene Certificate of Death Reg. No. 2007 200	72
	1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death	1
ledical Examiner	Samuel Benjamin Rosenberg June 23, 2007	
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Shady Grove Hospital 4c. County of Death Montgomery	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or	_
Director	179-54-4401 1X M 2 F 47 Yrs. Months Days Hours Min. Oct. 14, 1959 Foreign Country) PA	
any was the waster and a single	10a. State 10b. County 10c. City, Town or Location . 10d. Inside City	
Maryland 28a-f show d at once, rector	MD Montgomery Gaithersburg $\frac{1}{X}$ Yes 2	No
the Maryland or 28a-f sh iffed at once	10e. Street and Number	
atin with the items 23a ust be notifi	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black	,
호 6레 교	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: White	
ours aft	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry	
5-0036 lied within 72 hours after Hygiene. to ther than "natural", the Medical Examiner. Completed by	Elementary/Secondary (0-12) College (1-4 or 5+) Manager Restaurant	
-003 1 within giene. Ither th	5 Manager Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	-
21215-0036 Mental Higher within 7 Mental Hygiene. re event, the Medica To Be Comple	David Ellis Rosenberg Theodora Alexandra Bellas	
2 21 should and Me is man atic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
traum	Piyarat Bumrungsiri - Wife 106 Smoothleaf Lane Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State	
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is rr injury or other traumatic	1 Natural 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Union Cemetery 7/2/07 Steubenville, OH	
altin mit. P partme portar ury or	4 Donation 5 Other Specify: Union Cemetery 1/2/0/ Steubenville, OH 21. Signature of Funeral Service Accessee 22. Name and Address of Facility Greco-Hertnick Funeral Home	
	23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate In	oton (al
Physician /Medical	failule. List only one cause on each line. Between Onse Death	
taminer .	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	
_	Sequentially list conditions, b	
ted Insit Examiner	cause. Enter Underlying Cause	
Exal	events resulting in death) Last Due to (or as a consequence of):	
'60, sate be execute physician and re burial - trar	X UNPENDED #25a,2/,28a-1, perML,9869, 7/0/07 11	
ox 68760, ant certificate be executed attending physician and for use as the burial - transit sician/Medical Ex	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. Date of delivery Month Day Yes	
Box 687 death certific the attending ped for use as th	23b. Was decedent pregnant in the past 12 months?	ar
D. Box 687 the death certific. by the attending packed for use as the Physician/I	1 Yes 2 No 9 Unknown g Unknown	450
signed by the detached	1 Yes 2 No 3 Probably 4 Vunk	
Records, The law requires ficate has been sig , page 2 should be Completed	24a. Was an 24b. Were autopsy findings av	
e law r e has b ge 2 sh	autopsy performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2	No
Division of Vital Records, tal or Attending Physician: The law requir is after death. In Director: After this certificate has been set in by the funeral director, page 2 should bertification; To Be Completed	25. Was case referred to medical 26. Place of Death (Check only one)	
f Vital Physician or this cert al directo	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other: Other 4 Nursing Home 5 Residence 6 Other:	
n of \ding Phy 1. After th funeral c	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 1	
ision Atten er death rector: by the	2 Accident Investigation Investigation FND 6/23/2007 FND 4:20 pm CIRC Accident FND 6/23/2007 FND 4:20 pm CIRC CIRC	er, City
Division o Bispital or Attending 24 hours after death. Finneral Director: Afte	Suicide 6 X Could not be determined (Specify) house 100 Smooth Leaf Ln. Gaithersbur	g, M
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi Medical Certification; To Be Completed by Physician/Medical E	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
To with To con	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
	O.C.M.E. June 24, 2007	
	30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State	31. Date filed (Month, Day, Year) 3 Registrar's Signature	-
Registrar		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per inf 870 8-21-07

State of Waryland Department of Health and Mental Hygiene

amend item 19b per inf 870 8-21-07 beath

Reg. No. 200 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Babe STone 2:45PM JUMP 25,2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Frederick Hospital f Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**№** M 2□ F 76 578-36-2902 Yrs. Director July 17, 1930 North Caroling Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Montgomery 84 Mary land 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Columbia Pike# A6 USA 20910 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 10 Yes 2 □ No If Yes, Give Year or Dates: 1952 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Whit 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Associate Furniture 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NWONNIND Mabe ္ပ 19a. Informant's Name/Relationship (Type. Print)

Darlean Horseman— sister Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2-3. (A. Narth Glebe Rd. Montross, Va. 22520-4055 PYTICHAN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20b. Place of correlatory or other place,

Williamsburgmem pk 6-36-01 Williamsburg

22. Name and Address of Facility

White pocahon tast trial Williamsburg

Approximate Interval Between Onset and Death

Approximate Interval Between Onset and Death 1 Burial 2 ☐ Cremation 3 □Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee obert 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** FINFARCTION MYOCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it is a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: or Attending Physician: The law requires that the death certificate be executed the attending physician and ched for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 2 □ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Psychoses Atypical 1 Yes 2 No 3 Probably 4 Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? osteo-authritis 1∐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ☐ ER/Outpatient 3 ☑ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) within 24 and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D. 30469 June 26, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NB VELLANKI, 8850 COLUMBIA 100 PARKONY # 308 COLUMBIA: MD. 21045 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

JUN 2 7 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. anend items 7,8 per fh 9868 6-27-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death :59 M Month Year Physician 17 07 /Medical (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1 OY Inder 24 Hrs. 1936 MOR Date of Birth (Month, Day, 6. Sex Birthplace (State or Foreign Country) **Funeral** 219-26-1290 Months Days Hours 1 M 2 □ F 71 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ratural", or items 23a or 28a-f show any injury or rother traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 1XYes 2 □ No Director NIA MARYLAND 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Giv*e* Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 THGRADE OVING HAULING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ THEODORE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VE MD. 2/2/5 IKKOL H (DAUGHTER) UL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS 21. Signature of Funeral Service Licenses 22. Name and Address of Facility TON BALTO.MD.2121 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician mmediat. U /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed Due to (of as a consequence of) burial-trar and P.O. Box 68760. physician Physician/Medical the as attending IF FEMALE: To the Funeral Director; After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>^</u> 4 nknown 1 ☐ Yes 2□ No 3 ☐ Probably Completed 245. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a, Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3□ DOA Certification: To this 27. Man r of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of within 24 hours after death. To the Funeral Director: After 1 Natural
2 Accident 5 Pending investigation Injury 1 🗌 Yes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) AMSE MD 31. Date filed (Month, Day, Year) gistrar's Signature State JUN 2 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Charles W. Sloat 111 2:30 AM 23 2007 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. May 3 1, 1930 . Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** New York 77 1 M 2 □ F 097-22-1299 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits or 28a-f show a notified at 10a. State 10b County Essex MD Baltimore 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or be 21221 USA 214 Nanticoke Road items 23a must filed within 72 hours after death 1 Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1▼IYes 2□No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status ner Black, White, etc. 1 ☐ Never Married 2 ☐ Married "natural", or if edical Examin Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation Medical 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) the Me Elementary/Secondary (0-12) College (1-4or 5+) Aero Space Draftsman 12th 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Elizabeth Burnz Charles W. Sloat 11 ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages in Experiment of Health an Important: If item 27 is 2803 LaLoma Drive #34 Ranco Cordova CA MArie Sloat-Perdigone 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Dourial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Cemetery 6/27/07 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign ture of Fundra Santice Tre see 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or consthered shock, or heart failure. List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a cause on each line. Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) ntra Cranial Hemorrhage /Medical Due to (or as a consequence of): Examiner Myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Luc to (or as a consequence of): Examine that the death certificate be executed and Due to (or as a consequence of) physician a s the burial-Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Linknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ► No 24a. Was an certificate has birector, page 2 s autopsy performed? 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 10 2 ER/Outpatient 3 ☐ DOA this 27. Manper of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: To the Hospital or Attending within 24 hours after death. Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.O. Division or Vital Records,

> Registrar DHMH 17 Rev 1/2001

1

State

29a. Certifiei

one)

(Check only

31. Date filed (Month,

29b. Signature and title of certifier

Medical

ORIGINAL

and manner stated.

32 egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

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Day, Year)

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1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Union Memorial Hospital, Baltimore, MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per verb 8868 6-27-07 vt. State of Maryland / Department of Health and Mental Hygiene 0 0 7 2 9

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- 503	Dhusia		1. Decedent's Name (First, Middle,		2 1					2. Date of D		Year	3. Time of Death	
100	Physici /Medio		NELLIE	STE	RN					June	•		6:10AM M	
	Examir	er	4a. Facility Name (If not institution,				4b. City, Town, o		of Death	00	June 24 2007 4c. County of Death Baltimore City			
i AA		- Tr	Good Samaritan 5. Social Security Number	Nursing B. Sex	7. Age (In yrs.	la et hirthda ul	Baltimo		er 24 Hrs.	8. Date of B			nplace (State or Foreign	
	Funeral Director	Ä	236 ~28 ~1963 Usual Residence of Decedent	1 M 2X F	85	Yrs.	Months Days	Hours		(Month, D	5,1922	W.	VA.	
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	er de	Funeral Director	11. Marital Status	Armed F		J.S. 13. V	as Decedent of F Yes, specify Cub	Hispanic C an, Mexic	rigin? (Sp an, Puerto	ecify Yes or N Rican, etc.)	lo- 14. R.	ace - Amer lack, White	ncan Indian, e, etc.	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 Is marked other then "naturel", or Items 23a or 28a-f show or other traumatic event, the Madical Examinar must be notified.	by	1 Never Married XX Marrie 3 Widowed 4 Divorced	If Yes, G Year or I		1	1 ☐ Yes 🏋 No Specify:					ify: Wh	nite	
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lan	2 sho and !	•	19a. Informant's Name/Relationshi	р (Туре, Print)		19b. Mailin	g Address (Street	and Num	ber or Run	a <i>l R</i> ou <i>te Nu</i> mi	ber, City or Tow	n, State, Z	ip Code)	
	1 and Health em 27 Ither tr		Laura C. Wilson	ı (Daught			Poplar F	Rd. B						
00.0	Pages 1 nent of H int: If Ite		20a. Method of Disposition (☐ Burial 2 ☐ Cremation		State		atory or other pla	сө)		Date	20c. Location	,		
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	Physician		shock, or heart failure. List o Immediate Cause (Final	niy one cause on	each line.								Interval Between Onset and Death	
9	/Medical		disease or condition resulting in death)	a. Due to	or as a consec	uence of):								
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.O. B	Physicisn: The law requires that the death certif this certificate has been signed by the attending rat director, page 2 should be detached for use as	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		nant at time of c							Month Day Year		
<u>α</u>	that the ed by detac		Part II. Dther significant condition	s contributing to	death but not res	sulting in the un	derlying cause giv	en in Part	t I.	23e. Did	tobacco use co	ntribute to	the cause of death?	
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ita	ysicisn: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?					26. Plac	ce of Deatl	1 ☐ Yes	2 No one)	1 🗆 Yes	2 No	
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	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	(Check only 2 Medical E	xamıner: On the t	basis of examina nner stated.	ation and/or inv	estigation, in my o	opinion, de	ath occurr	ed at the time	, date and place	, and due	to the cause(s)	
	To th withir To th comp	M	29b. Signature and title of certifier				29c. Licens	se number	,		29d. Date sign	ed (Month	, Day, Year)	
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	5		30. Name and address of person w	po completed cau	ise of death (Iter	п 23а) (Туре, Р	rint)	1	1	2, 0)		215 05	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE **Physician** 3:15P JULIA M. SCHWARTZ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner OAKCREST VILLAGE CARE CENTER BALTIMORE COUNTY BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Yrs. Director 19,1909 212-03-6465 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County XXYes 2 □ No Director Maryland Baltimore City Baltimore City 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21206 6119 Alta Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2X No Specify: Completed by XX Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 yrs. Clerk C. & P. Telephone Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important: If itsm 27 is marked i any injury or other treumatic sv Charles A. Jones Margaret Moran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret V. Harris (Daughter) 15 Juliet Lane Condo #101 Baltimore, Md. 21236 20b. Place of Disposition (Name of cemetery, crematory or other pla Gardens of Faith 20a. Method of Disposition Date 20c. Location - City or Town, State XBurial 2 ☐ Cremation 3 ☐ Removal from State 6-27-07 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lassahn Funeral Home E. F. Lassahn 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the Mease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physiclan/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient Medical Certification: To 3 DOA 27. Manne of Death 1 Natural 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Ucertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title D61785 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 Walther Blud Parkville, MD 71234 200 Sha

Registrar

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31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

32. Pegistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Registrar Amend #1, per Loc. #14, per FH, 6868, 6/2/Orificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Vear 7:22 PM Silva Sun-Pok Silva June 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center N/A Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours Min. 1 M 2 Y 241-77-4308 Director 4-6-1956 Korea Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐Yes 2 ☐ No NA Funeral Director Lorton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or Items 23a or 9252 Ashland Woods Lane 22079 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 No If Yes, Give Specify: Black Asian 1 ☐ Yes 2 ☑ No Specify: Completed by Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th grade Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evonce. ٩ So-sue Kim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leeman Silva 9252 Ashland Woods Lane, Lorton, Va. Husband 22079 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cem. 6-20-07 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F. H. East D 1101 E. North Ave., Baltimore, Md. 21202 wan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Severe Sepsis 1 month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Graft Versus host disease 2 No 3 Probably 4 Unknown 1 TYes 24a. Was an autopsy performe Myelodysplastic syndrome 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1∐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one Certification: To Be 1 ☐ Yes 2 🕱 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 XNatural 5 Pending investigation

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Division or Vital Records, P.O. Box 68760, been signed by should be detact certificate has birector, page 2 s After

the Maryland

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director:
completely filled in by the f

State Registrar

Medical

29c. License number

1 💢 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

6 ☐ Could not be

determined

P19840

1 ☐ Yes 2 ☐ No

June 14, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

22 South Greene Street Baltimore, MD 21201 M.D leng

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year)

2 Accident

3☐ Suicide

29a. Certifier

4 Homicide

(Check only one)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #31, perDVR, g808, 0/2//0/ TI Certificate of Death Reg. No. 🛴 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 24 \mathbf{P}^{M} SILBERSTROM JUNE 2007 3:20 BETTY /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY ROCKVILLE CASEY HOUSE If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 ☐ F POLAND 02/05/1921 86 215-30-2527 Director Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or items 23a or 28a-f show 10c, City, Town or Location 10d. Inside City Limits 10b. County 10a, State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at BALTIMORE BALTIMORE 1 ☐ Yes 2 No Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21209 6803 SYLVALE COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: ģ 3 ☐ Widowed 4 ₩ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS CLOTHING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be STYCZEN SARA WOSK မ AARON Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5455 HALFLIGHT GARTH - COLUMBIA, MD 21045 MERLE ROSS / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 'Department of H Important: If ite any injury or of 1 Burial 2 □ Cremation 3 □ Removal from State BETH TFILOH CONG. 06/26/2007 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Matt Cer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MULTIPLE MYELOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the local first lander in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner sician and burial-transit that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, physician the as attending I IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year in the past 12 months? signed by the a ☐Yes 2☐No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 【 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No page 2 s 1□ Yes Division or Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 26. Place of Death Check onl one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 DOther (Specify) HOSPICE 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 1 TYes ٩ funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 5 ☐ Pending investigation 1 🕅 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0064615 JUNE 24, 2007 mi 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

JUN 2 7 2007

31. Date filed (Month, Day, Year)



			For State	State of Mai	ryland / Depa <i>Cel</i>	artment of H r <i>tificate of I</i>		, ,	iene 200	7 20733
			Registrar Decedent's Name (First, Middle, Li	ast)		timodio or a		2. Date of Deat	h	3. Time of Death
	Physici		Dorothy K. Ti	llman				June 24	. 2007	6:20 P ^M
	/Medic Examin		4a. Facility Name (If not institution, gi			4b. City, Town, or	Location of Death		4c. County of [
- 242		Н	Future Care Trin	ity House		Baltimor		10.001(5)1	n/a	81
	Funeral		,	Sex 1 M 2 X F 89	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)
Į,	Director		212-05-0085 Usual Residence of Decedent	05				Aug. 8,	1917	Maryland
	ylanc how at		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e Ma Ba-f s	ctol	MD Baltimo	re	Towson	_				1 □Yes 2 X No
	or 28	Director	10e. Street and Number			10f. Zip Code			0g. Citizen of Wha	t Country?
	sath v	Funeral	409 Virginia Ave	Apt. 218 12. Was Decedent Ev	verin IIS 13	21286	ispanic Origin? (Sp		USA 14. Bace - A	American Indian,
	fter de r Item iner J	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	D	Was Decedent of H If Yes, specify Cuba		Rican, etc.)		White, etc.
3	al", o	by	3 Nidowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify:	White
215-0036	72 ho 'natur dical	eted	15. Decedent's E (Specify only highest g	iducation rade completed)	16a. Dece	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work	king	16b. Kind of Busin	ess/Industry
7	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired omemaker	1)		Own H	nme
N	filed v Hygie ther t	ပ္ပ	12 17. Father's Name (First, Middle, Las	it)	П	MIEMAKEI	18. Mother's Nam	e (First, Middle, M		OIIIC
<u>a</u>	ld be ental ked o	To Be	Thomas Kaiser				Charlott	e Mille	r	
Maryland	shou tnd M s mar umat	-	19a. Informant's Name/Relationship	(Type. Print)	19b. Mailir	ng Address (Street	and Number or Ru	ral Route Number	; City or Town, Sta	ite, Zip Code)
Ĭ,	and 2 salth a 27 Is er tra		John J. Tillman	(son)	3722	Dance Mi				
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from State		matory or other plac	ce)		20c. Location - City	
Ē	:. Pag tment tant:		4 □ Donation 5 □ Other (Spec	ify)	Most Holy	y Redeeme		3/2007	Baltimor	e, MD Home, Inc.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatur of Funeral Service Lice	insee		2. Name and Addre 050 York			21204	nome, inc.
			23a. Purt1. Errer the disease, or con shock, or heart failure. List onl	nplications that caused t	9			or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	y one cause on each line	(9055.	1 0	teeD			Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of):					
	Examiner	L	Sequentially list conditions, if any, leading to immediate	b	10 r					479
/	ted sit	niner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):	Ballam	^			1
,	execu	Examine	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):					719
8/60,	icate be executed physician and s the burial-transit	dical		d						
O		Medi	IF FEMALE:							
ROX	w requires that the death certifi been signed by the attending should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1☐Live birth 2	2 ☐ Fetal death 3 ☐	Ectopic pregnancy	/		23d. Date o Month	f delivery Day Year
<u>.</u>	the a	ysic	1 Yes 2 No 9 Unknown	4□Pregnant at t 9□Unknown	time of death 5L	☐ Other (specify) _				,
1	law requires that the as been signed by the 2 should be detache		Part II. Other significant conditions	contributing to death but	t not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tol	bacco use contribu	ite to the cause of death?
Hecords,	quires n sign ald be	d by	OST	white co	•			1 □ Y	es 22 No 3[☐ Probably 4 ☐ Unknown
ပ္ပ	aw rec s bee 2 shou	Completed						24a. Was a	n 24b. Wei	re autopsy findings available
	The la	mo						autops perfori 1□ Yes	med? dea	r to completion of cause of th? Yes 2 No
VItal	siclan: The law certificate has t irector, page 2 s	BeC	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only on		
o 	Sie de	101	1 ☐ Yes 2 ☐ 1 0	Hospital: 1 Inpatien			Nursing H		ence 6 DOther	(Specify)
	ding Phys h. After this of funeral dire	ü	27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injury (Month, Day		Wor	yat k? Yes 2 ∐No	28d. Describe ho	ow injury occurred	
DIVISION	death ctor: y the	icat	2 Accident investigati 3 Suicide 6 Could not	be 28e Place of injur	ry - At home, farm, st		165 Z 🗆 140	28f. Location (St	treet and Number o	or Rural Route Number,
≧	after after Dire	Certification:	4 ☐ Homicide determine	building, etc.	(Specify)			City or Town	n, State)	
	To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		(Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of	examination and/or ir					
	o the lithin 2 of the loothe l	Medical	29b. Signature and title of certified	and manner stat	ted.	29c. Ligens		2	9d. Date signed (A	Month, Day, Year)
)	⊢ ≯ ⊢ ŏ)	V		(4)	24271	>	625	-07
	01		30. Name and address of person wh				more. Mar	rvland 2	21224	
E_{i}	Sta	ate	31. Date filed (Month, Day, Year)	32 -Registra	r's Signature			J		
6	Regist		JUN 2 7	2007 Deline	JA A	well .				

within 24 hours after death

To the Funeral Director:
completely filled in by the To the

> State Registrar

DI

31. Date filed (Month, Day, Year) JUN 2

M

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. Charles St Baltymore

00057926

29d. Date signed (Month, Day, Year)

24,2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Dorothy June 25, 2007 1:50 P White /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** College Manor Lutherville Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 F 29,1921 Director 036-12-7899 85 Rhode Island Aug. Usual Residence of Decedent the Maryland a or 28a-f show be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Lutherville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a any Injury or other traumatic event, the Medical Examination r than "natural", or Items 23a the Medical Examiner must b 8413 Tally Ho Road 21093 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. 3X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant Baltimore Co. Gov't. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Charles Salsteen Lydia Ann Dodd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane O'Conor Daughter 8413 Tally Ho Road Lutherville, Maryland 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 6-26-2007 Towson 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** days unon disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy perform 1 Yes 2 2∐No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) & 95; 5 Ped (/V/) 1 ☐ Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

19

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ted Hork 7402 York Rd # 34 touk

31. Date filed (Month, Day, Year) JUN 2 7 2007



10WSON

			For State Ragistrar	State of Maryl	and / Depa	artment rtificate	t of H	ealth a Death		F	Rag. No.	07	20736	
	Physicia	an	1. Decedent's Name (First, Middle, Last Marie Weidner)						2. Date of Dea Month June	Dav	007	3. Time of Death 11:00 P M	
	/Medic	al	4a. Facility Name (If not institution, give	street and number)		4b. City.	Town, or	Location of		Julie		nty of Death		
	Examin	er	Kensington Nursin			Kens					Mont	gomer	У	
	Funeral Director		5. Social Security Number 6. Se 192–03–7286		yrs. last birthday; Yrs.	If Under Months	If Under 1 Year If Under 24 Hrs. 8. Date of Birt Months Days Hours Min. Nov. 28					9. Birth Penn	nplace (State or Foreign untry) sylvanian	
	and w		Usual Residence of Decedent 10a. State 10b. County	10c	. City, Town or Lo	ocation					10d. Inside City Limits			
	Maryl -1 sho	ţ	Maryland Montgome	ry Ke	ensingto	n							1 XYes 2 No	
	th the	lrec	10e. Street and Number			10f. Zip					10g. Citizen		•	
	ath wi	ral	3000 Mc Comas Avei			208	_		: 0 (0	7 1/2	U. S. A.			
920	be filed within 72 hours after death with the Maryland ital Hygiene. ad other then "natural", or items 23a or 28a-f show event, the Medical Evanirar must be retilled at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	in U.S. 13.	If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)		Black, White		
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	edent's Usua kind of wor	rk done a	luring most	t of workir	ng	16b. Kind o	f Business/l	ndustry	
121	within iene. r then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		Home 1				ļ	Priva	ate		
5	e filed v al Hygie other t vent, to		17. Father's Name (First, Middle, Last)			nome .			er's Name	(First, Middle,	Maiden Sur	name)		
Maryland 21215-0036	Mer Mer prke	To Be	19a. Informant's Name/Relationship (7	ivoe Printl		nown	(Street a	and Numbe	er or Rura	l Route Numbe	ar. City or To	wn. State. Z	unknown	
Ma	12: har 7 is trau		Attorney Steven W	•	4	•				103 Wa				
ē,			20a. Method of Disposition	20	Ob. Place of Disp cemetery, cre					ate			Town, State	
Baltimore,	permit. Pages of Department of Important: If Ite any injury or of once.		1 ☐ Burial 2/A Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Hemovai irom State	Riverda	le Cr	emat	ory			River	lale,	Maryland	
alti	permit. Departrimports Imports any inju		21. Signature Funeral Service Licen.							ney's F				
	20 E 29 9			MD 278	3	831 G	eorg	ia Av	enue	, N. W.	Wash	,D.C.	20011 Approximate	
	Physician	P 1	23a. Part1. When the disease, or compositions, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Deme:	ntia	iter the mod	or dynn	g, 3doi1 d3	Cardido o	Trospilatory at			Interval Between Onset and Death	
	/Medical Examiner		Toodhing in asality	Due to (or as a coe	_									
		ē	Sequentially lisl conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a cor										
	be executed sician and burial-transit	Examiner	that initiated events	c										
oʻ	e exer ian ar urial-t		resulting in death) Last	Due to (or as a cor	nsequence of):									
8760,	cate b	dicai		d										
. Box 68	ie death certificate be executed the attanding physician and hed for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12,months? 1 □ Yes 2 □ No	1 Live birth 2 🗌	ic. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)						23d. Date of delivery Month Day Year			
P.0	that the ded by the detached	Phys	9 Unknown	We shall be a second		4		:- Dad I		220 Did :	abacca use	oontributa to	the cause of death?	
Ś	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but no	t resulting in the	underlying d	ause give	en in Parti		1 🗆 1	_		obably 4 Unknown	
Record	0 5 0	Completed								24a. Was autoj perfo 1 Yes		prior to death?	utopsy findings available completion of cause of 2 No	
Vital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?						of Death	(Check only o	опе)			
of V	S 5	2	1 ☐ Yes 2 🔀 No		2 ER/Outpatie			4 (2011)		me 5 ☐ Resi 28d. Describe			cify)	
		ion	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye.	ar) 28b. Time Injury	M A	28c. Injur Wor	yaı k? Yes 2. ☐		Zou. Describe	now injury or	JCUIT BU		
Division	or Atten ifter deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		At home, farm, s pecify)					28f. Location (City or To		umber or Ru	ural Route Number,	
	To the Hospital within 24 hours a To the Funeral completely filled	Medical Co	29a. Certifier 1 X Certifying Ph (Check only one) 2 Madical Exam	ysician: To the best of my ninar: On the basis of exa and manner stated.	y knowledge, dea umination and/or i	ath occurred investigation	at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the ed at lhe time,	cause(s) and date and pla	d manner as	s stated. e to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and the of certifier	1		29	c. Licens	e number			29d. Date s	igned (Mont	h, Day, Year)	
	- s - o		//. X . \	Ma		H	10051	.280			June	27, 2	007	
	h		30. Name and address of person who		(Item 23a) (Type	e, Print)								
_	J				t Avenue	, Ken	sing	ton,	Md.	Citize	ns Ban	k Bui	lding	
	St Regist	ate rar	31. Date filed (Month, Day, Year)	a2. Registrar's	Signature	als)								

DHMH 17 Rev 1/2001

Melissa Brassell, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year,

OCME

30. Name and address of person who completed cause of death (Item 23a)

. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

State Registrar

Physician /Medical Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, attending physician

in by the

has

: After

Examiner

Physician/Medical

2

Completed

Be

P

Certification:

Medical

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iten any injury or other traumatte event the Madical or Iten

Maryland

Baltimore,

 \mathcal{C}

Directo

Funeral

þ

Completed

Be

IF FEMALE 23b. Was decedent pregnant

5 ☐ Pending investigation 6 Could not be

1 ☐ Yes 2 ☐ No

29a Certifier

3☐ Suicide

4 ☐ Homicide

1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ouvence & Gallager, MD

29c. License number DO1786 29d. Date signed (Month, Day, Year) JUNE 25, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LAURENCE R. GALLAGER, MD 716 MAIDENCHOICE LANE, CATONSVILLE, MD ZIZZ8

State Registrar

31. Date filed (Month, Day, Year)



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

Hospital or Attending Physician:

death.

To the Hospital within 24 hours a To the Funeral I

after death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc 8869 7 6 07 of Health and Mental Hygiene Certificate of Death Raymon William Williams Williams 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician (A9116NA) JUNE 22 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL CONTER RANDAMETON Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** MD Director 215-02-5194 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director MD Baltimore Gwynn Oak 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 28 Summerfield Road 21207 USA 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2√7 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo SpeciAfrican-Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Amorican 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Self Employed Elementary/Secondary (0-12) College (1-4or 5+) Tow Truck 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James E. Williams Lauretta Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy H. Williams/ Wife 28 Summerfield Rd., Gwynn Oak, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burnal 2 Scremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 6/28/07 Crematory Baltimore, MD 22. Name and Address of Facility Wylie F/ H P.A. of Balto.Co 21 Analyre of Funeral Service Licensee 9200 Liberty Rd., Randallstown, MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner NECROTIZIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence-of) Examiner death certificate be executed Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) Records, P.O. the 9☐ Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Jas autopsy performed 2 H M Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 patient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 27. Manner of Death 1 → Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 19502 VUNE 22, 2007 Nonthwest Hospithe Contar RANDAUS TOWN, MANYLAND 21133 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 CONANAN DRIANDO

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. MEND 115W/12 104 per INF (369 7/18 107 WS) State of Maryland 7 Department of Health and Mental Hygiene U U /

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 8:30 PM 21 JUNE 2007 THEODORE ROOSEVELT WILLIAMS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VETERAN'S ADMINISTRATION MEDICAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1(XM 2□F 579-52-0756 Director 67 4-28-1940 N.C. Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or Items 23a or 28a-f show vent, the Medical Examiner must be notified at Md. 1X Yes 2 □ No Director Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f Zip Code 5819 Plumer Avenue 21206 USA Pages 1 and 2 should be filed within 72 hours after death viet of Health and Mental Hygiene.
Instit If lean 27 is marked other than "natural", or Items 23s into 18 the contract reaumatic event, the Medical Examination found. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 257No If Yes, Give ↑ Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Correctional Elementary/Secondary (0-12) College (1-4or 5+) Medical Physican Baltimore Co. 12th grade PHD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Henry Williams Julia 2 Π. 19a. Informant's Name/Relationship (Type, Print) Fiancee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherby Thomas Friend 5819 Plumer Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or otl 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forset Vet. 7-2-07 Owings Mills, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md. adap 21202 an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YEARS PULMONARY HYPERTENSION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to introducte cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physicien and s the burial-translt Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death signed by the at the detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ivision of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No certificate has t lirector, page 2 s 24a. Was an 2 No 1 ☐ Yes director. 25. Was case referred to medical examiner? Medicai Certification; To Be 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ■Inpatient 2 □ ER/Outpatient 3 □ DOA 1 ☐ Yes 2 🔀 No After this funeral (27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Tes 2 No within 24 hours after death To the Funeral Director: A completely filled in by the f 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) JUNE, 21, 2007 P21168 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. R. AHSARI

DHMH 17 Rev 1/2001

State Registrar

10

32. Registrar's Signature

31. Date filed (Month, Day, Year) JUN 2 7 2007

NORTH GREENE STREET BALTIMORE, MD 21201

4b. City, Town, or Location of Death

Towson

2. Date of Death

June 24,

.^{Day}2007

4c. County of Death

Baltimore

3. Time of Death

5:50P M

Physician /Medical **Examiner** 1. Decedent's Name (First, Middle, Last)

Philip Charles

4a. Facility Name (If not institution, give street and number)

Blakehurst 1055 West Joppa Road

Wagley

Funeral Director

death with the Maryland 28a-f show Examiner must be notified at Director 0 or items 23a Funeral Pages 1 and 2 should be filed within 72 hours after "natural" Completed than permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Monee. Be

by

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Examine and attending physician for use as the buria Physician/Medical ed by the a <u>á</u> Completed this certificate director. Be 2 After thi Certification: Medical

within 24 hours after deal To the Funeral Director, completely filled in by the

or Attending Physician; The law requires that the death certificate be executed the Hospital

Division or Vital Records, P.O. Box 68760.

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | Month, Day 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Months November 19, 1920 1**X**XM 2□ F Pennsylvania 86 184-05-8152 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2XXVo Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1055 West Joppa Road 21204 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Wes 2 □ No WW I I If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2XXNo XX Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Dentist Dentistry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Charles Wagley Catherine Schlegelmilch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen B Wagley DTR 1962 Shadow Valley Drive Prescott Arizona 86305 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State □Donation 5 □ Other (Specify) Holy Trinity Cemetery 6/29/07 |Columbia,Pennsylvania ignature of Fun 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 thons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or complicat shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myoTROPH'C Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No perforn 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Aesidence 6 ☐ Other (Specify) 1 ☐ Yes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🧭 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DANE 25, 2007 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) CATTON WOODS B. BATTOMPE, M.D. 8813

DHMH 17 Rev 1/2001

State

Registrar

gistrar's Signature

MININSOFW

2007

31. Date filed (Month, Day, Year)

JUN 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Qata of Death 1. Decedent's Nama (First Middla, Last) Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days **Funeral** 10M 20 F Months Hours 212-56-253 Director Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Heelth and Mentai Hygiene. Important: If Item 27 is marked other than "naturel", or items 23a or 28a-f ahow eny injury or other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 10a Stata 10b. County 10c. City, Town or Location 1 Tas 2 □ No Director yary and 10g. Citizan of What Country? 10e. Street end Number 10f. Zio Code Braddist Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Raca - Amarican Indian, 11. Marital Status 12. Was Decedent Evar in U,S. Armed Forcas?

1 Vas 2 No
If Yas, Give
Year or Datas: Black, Whita, atc. 1. Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Kouter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown Grace Wn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number of Rural Route Number, City or Town, Stete, Zip Coda) Alston -son Braddish Ave Markco Baltimore Marylar 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 Removal from State Battimore Marylar 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Further Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final diseasa or condition resulting in death) /Medical Examiner Physician/Medical Examiner The law requires that the deeth certificate be executed ed by the attending physician and deteched for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown δ 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed eral Director: After this certificate has filled in by the funerel director, page 2 2 No 1 ☐ Yas 2 ☐ No To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica Be 25. Was case refarred to medical axaminer? 26. Placa of Beath (Check only ona) Hospital: Othar: 4 | Mursing Home 5 | Rasidanca 6 | Other (Specify) 1 ☐ Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 1 Natural 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signatura end titla of certifier

31. Data filed (Month, Day, Year) JUN 2 7

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar **DHMH 16 Rev 6/95**

29c. Licansa number

1600 W. MOUNT Royal Are

29d. Date signad (Month, Day, Year)

6-20-07

Ballo MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1/ per inf 9869 7-6-07 vt.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Ziemski Louise Mary 7:02 A M 2007 23 June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Towson Gilchrist Center If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 22,1939 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Days 1 □ M 2 🔀 F Yrs. 67 Maryland 213-36-4006 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Maryland Edgemere Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21219 6807 River Drive Road United States
14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Archdiocese of Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Teacher Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Budzik Clara Kisielewski Joseph Andrew Dudzie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6807 River Drive Road Baltimore, Maryland 21219 Mr. Gilbert Ziemski (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht. of Mary Cem. 6/27/2007 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licenses \sim 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition bladder Gall disease or condition resulting in death) concer month Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2000 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Medical Examine **Physician** /Medical Examiner Division or Vital Records, P.O. Box 68760,

certificate be executed and burial-trar attending physician the as for the detached page 2 Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director, To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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Funeral

Completed

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Physician/Medical

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Certification:

Medical

29a. Certifier

29b. Signature and title of certifier

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen M. Gordon 31. Date filed (Month, Day, Year)
JUN 2 7 2007

6565 H. Charles St Boutmore MD 21204

and manner stated.

32. Registrar's Signature

MD

🗡 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0051926

29d. Date signed (Month, Day, Year)

23 2007

lune

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Month Year Tia Archibald ам 2007 8:35 June 6, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hebrew Home of Greater Washington Rockville Montgomery Hours Min. 8. Date of Birth (Month, Day, Year)
Aug. 25, 1940 If Under 1 Months Social Security Number . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 € F Jamaica 218-68-3728 66 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Director Rockville Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or Items 23a or USA 4819 Randolph Road 20852 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritaf Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☒ No Specify: Specify: Completed by 3 Widowed 4 Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nursing 12 Certified Nursing Assistant permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 is marked otherny injury or other traumatic event, SMEB. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jane Simpson Albert Senior 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4819 Randolph Road, Rockville, Md 20852 Gerald G. Archibald/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 23, 2007 Silver Spring, Maryland Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Funeral Home Inc. Lund 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. It for the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTA COLUN /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): ettending physicien end for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, đ IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate has page 2 1 ☐ Yes 21410 or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death Check only one examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Naturaf 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 06/06/07 D0061096 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHA GOLLAPALLI 6121 MONTROSE ROAD, ROCKVILLE, MD 20852 32 Pegîstrar's Signature 31. Date filed (Month, Day, Year) JUN 13 2007

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of Maryla			of Health of Death		ental Hy	/giene Reg. No.	007	20745		
177			Decedent's Name (First, Middle, Last	it)					2. Date of D	eath		3. Time of Death		
	Physici		Mary Beatrice	Armstrong					Month June	16. Z		6:32 a N		
8	/Medic		4a. Facility Name (If not institution, give			4b. City, Tow	vn, or Location	of Death			County of De			
		÷	St. Mary's Nursir			Leonar					t. Mar			
	Funeral		Social Security Number 6. So	□M 2DXF	rs. last birthday) Yrs.	If Under 1 Y Months Da	ear If Under ays Hours	24 Hrs. Min.	8. Date of Bi (Month, D	ay, Year)	9. E	Birthplace (State or Foreig Country)		
	Director		220-16-8809 Usual Residence of Decedent	8	1				12/04/	1925	Ma	ryland		
	land ow		10a. State 10b. County	10c.	City, Town or Lo	cation						10d. Inside City Limits		
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	or 288	irec	10e. Street and Number	0	o.	10f. Zip Co	de			10g. Citi	zen of What	Country?		
	th wit	al	24389 Budds Creek	k Road		20624				Uni	ted St	ates		
936	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the <u>Medical Examiner must be</u> notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ◯ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	'	Vas Decedent fYes, specify I∐Yes 2. 🛣	of Hispanic Or Cuban, Mexica No Specify.	n, Puerto	ecify Yes or N Rican, etc.)	0-	Black, W Specify:	merican Indian, /hite, etc. Black		
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12	l withi piene. r than the M	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	Domest	tic Wor	k			Home	e			
b	12 should be filed w h and Mental Hygien 7 Is marked other ti traumatic event, th	BeC	17. Father's Name (First, Middle, Last)		•		18. Moth	er's Name	(First, Middle	e, Maiden	Surname)			
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Maryland	2 sho and I s ma		19a. Informant's Name/Relationship (7	Type. Print)	19b. Mailir	g Address (St	reet and Numb	er or Rura	al Route Num	ber, City o	r Town, State	e, Zip Code)		
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Baltimore,	ges 1 and It of Health If Item 27 or other tr		20a. Method of Disposition 1		o. Place of Dispo cemetery, crer	sition (Name o natory or othe	r place)	Ľ	ate	20c. Lo	cation - City	or Town, State		
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical (nysician: To the best of my nlner: On the basis of examand manner stated.										
	withir To th comp	Me	29b. Signature and title of certifier	_ /		29c. Li	icense number			29d. Da	te signed (M	onth, Day, Year)		
	2		1/1/4	m Thup		1	1428	5		6	.18.	07		
	N		30. Name and address of person who	completed cause of death (I	tem 23a) (Type,	Print)					- 0			
	N		William D. Boyd I		65 Point	Looko	ut Road	l, Le	onardt	own,	Mary1	and 20650		
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Si		to Otto								
	Regist	rar	JUN 1 9 20	101										

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20^{Day} Month **Physician** Helen Cecelia Allston 2007 June 2:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 14784 Pilea Place Hughesville Charles 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 K F 214-28-4080 78 Director September 21,1928 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits Examiner must be notified at Maryland Charles Hughesville 1 ☐ Yes 2 No Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14784 Pilea Place 20637 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes Ž No Specify 3K Widowed 4 □ Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Massey Shepherd George Paran Adams ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Allston / Son 14750 Pilea Place Hughesville, Maryland 20637 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Christ Church Cemetery Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State June 23, 2007 Chaptico, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home P.O. Box 270 Leonardtown, MD 20 Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final volon **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions of the conditions of the cause. Enter Underlying Cause (Disease or injury Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriah-transit completely filled in by the funeral director, page 2 should be detached for use as the buriah-transit resulting in death) Last Division or Vital Records, P.O. Box 68760. Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d Date of delivery 1☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 | Yes 2 | DN 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Pay, Year) pleted cause of death (Item 23a) (Type, Print) Manoj Panwala, M.D

Registrar

State

33767 Market Driv

Date filed (Month, Day

JUN 2 0

Charlotte Hall, MD 20622

32. Registrar's

	1 - For State Registrar	State of Maryland / Dep	artment of Health and I	Mental Hygien	L 0 0 1 L 0 1 1 1			
Physician	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death			
/Medical Examiner	Marina H. 4a. Facility Name (If not institution, give)		4b. City, Town, or Location of Death	Jun	C. County of Death			
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Funeral Director	5. Social Security Number 6. Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	7. Age (In yrs. last birthday 74 Yrs.	If Under 1 Year If Under 24 (Irs. Months Days Hours Min.	B. Date of Birth (Month, Day Yea Jan. 12,	1933 9. Birthplace (State or Foreign WV			
and *	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits			
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should and Men Ind Men	19a. Informant's Name/Relationship (T)	pe, Print) 19b. Mail	ling Address (Street and Number or Ru		y or Town, State, Zip Code)			
2 95 2	Jeffrey T. Booth (Box 733, Mount Ai	ry, Maryla	nd 21771-0733			
DETILITIONS, permit. Pages 1 and Department of Healt important: If item 2 any injury or other once.	20a. Method of Disposition 1 🔀 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	20b. Place of Disposer cometery, cre	Souls	e 13,	Location - City or Town, State			
mit. F partme portar / injur	21. Signature of Funeral Service Licens		22. Name and Address of Facility De		rmantown, Maryland			
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/Medical Examiner	disease or condition resulting in death)	Due to (or as a consequence of):	220000000000000000000000000000000000000					
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cate be ex physician the burial		Due to (or as a consequence of):						
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BOX OF Beath certific attending p	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of delivery Month Day Year			
T.C. BOX of the death certification of the attending let ached for use as physical and Me.	1 Yes 9 Unknown	4☐ Pregnant at time of death 5 9☐ Unknown	Other (specify)	Month Day				
that the detail		ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?			
w requires been sign should be				1 🗆 Yes	2 No 3 Probably 4 Inknown			
The lay ate has page 2				24a. Was an autopsy performed				
VITAL iclen: 1 Sertifical ector, p	25. Was case referred to medical	L	4	ath (Check only one)				
Or VITA Physicien: this certific ral director,	10 198 22 100	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 ☐ ER/Outpatient 28a. Date of Injury 28b. Time		lome 5 Residence				
on rth. : After	Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury		20d. Describe flow ii	indry occurred			
To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be C	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)			
he Hospita in 24 hours he Funeral pletely filled		sician: To the best of my knowledge, deaner: On the basis of examination and/or	ath occurred at the time, date and place investigation, in my opinion, death occu	n, and due to the cause arred at the time, date a	v(s) and manner as stated. and place, and due to the cause(s)			
Fo the within 2 comple	29b. Signature and title of certifier	and manner stated.	29c. License number	29d. l	Date signed (Month, Day, Year)			
10	I Ask of		mp DO00943	17.	F'015 01 su			
	10 500	ompleted cause of death (Item 23a) (Type	a, Print)	urgmo	7.05.3.5			
The second second	31. Date filed (Month, Day, Year)	32 Registrar's Signature	Ave Vaithusb	urgno	CO8 7 7			
State Registrar	11111 1 0 000		asti))				

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Physician

/Medical

Examiner

ig physician and as the burial-tran

signed by the a

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altimore, Maryland 21215-0036

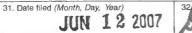
Hospital or Attending Physician: funeral after death I Director: / d in by the f To the Funeral Direct
To the Funeral Direct 10+1

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064615 June 8, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Genevieve Wroblewski, M.D., 1355 Piccard Drive, Suite 100, Rockville, MD 20850

State Registrar





VOID

CERTIFICATE

2007 - 20749

SEE

CERTIFICATE

2007 - 19541

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Gloria 10, Ann June 2007 Brewer 8:00 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 9524 Croom Road Upper Marlboro Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2X F 55 219-74-9346 03/10/1952 Washington DC Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1X Yes 2 □ No Maryland Prince Georges Upper Marlboro Director illed within 72 hours after death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9542 Croom Road 20772 USA 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status "natural", or item edical Examiner r Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: à Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Prince Georges Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Secretary Hospital 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be 1 Clara ပ Leon Brewer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health a Important: If item 27 Is any injury or other train Upper Marlboro, Maryland 20772 Tonya Warner/Daughter 9524 Croom Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Resurrection 6/15/07 Clinton, Maryland 21. Signature of parent Service Licensee 22. Name and Address of Facility Adams Funeral Home PA Dilley 20605 Aquasco Rd Aquasco, Maryland 20608 191 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC COLON Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner METASTASIS KETROPERITONEAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, by 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has perfor 1□ Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Plant hours after death. After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In Indicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43162 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POINT OR GREENBELT 7831 MELVIN W. GASKINS BELLE 31. Date filed (Month, Day, Year. State

DHMH 17 Rev 1/2001

Registrar

JUN 13

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Eugene Howell Blizzard 536M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5. Social Security Number Ba Hospital 1 timore 8. Date of Birth (Month, Day, June 21 6. Sex Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1**X** M 2□ F 215-58-5183 Director 53 June 1953 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f shov Examiner must be notified at 1 ☐ Yes 2X No Director PA York Delta 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 148 Flintville Road 17314 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Race - American Indian. Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 No Specify: White Completed by Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, College (1-4or 5+) 5⁺ Elementary/Secondary (0-12) 12 Teacher/Coach Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Maurice Blizzard Freda Stauffer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gay Blizzard/wife 148 Flintville Rd Delata, PA 17314 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 06/13/2007 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation, Inc Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Fitts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Metasta noreatie disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine To the HospItal or Attending PhysIclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 9☐Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown has been signed to a should to 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 읃 1 Yes 25 No 1 /\(\int\)npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Natural 5 Pending 1∏Yes 2∏No investigation 2 Accident Director; 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)) y w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore, Md 21237 Year) Régistrar's Signature 31. Date filed (Month 2007 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Willard Jay Beach 7:02 AM Tun 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F Months Days Hours 216-40-9080 Director November 9, 1943 63 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at St. Mary's Coltons Point Maryland Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20626 20248 Breezy Point Road permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygene. Important: If Item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must anone. IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 No 1 ☐ Yes 2 ☒ No þ Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Heavy Equipment Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Zenobie O. Williams Thomas Jefferson Beach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20626 Hilda Fay Beach / Wife Coltons Point, MD P.O. Box 123 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Faith Episcopal 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐Removal from State June 20,2007 Mechanicsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P. P.O. Box 270 Leonardtown, MD 20650 P.A. 23a. Part1. Enter the disea: , or confilications that cause shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIAC **Physician** DYSLYTHMIAS MINUTES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHAMIC OBSTRUTTIVE DILWENTY DISETTE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed MCLLITYS 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 112 Natural 5 Pending investigation 2 Accident 1 □ Yes 2 □ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

The law requires that the death certificate be executed Records, P.O. Box 68760 Division or Vital Hospital or Attending Physician: iin 24 hours af the Funeral D ppletely filled i within 2

with the Maryland

Baltimore, Maryland 21215-0036

State Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Snang 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 1 8 2007

ORIGINAL

MD

29c. License number

29d. Date signed (Month, Day, Year) 6-14-07

LEWARD JOHN MD 28680.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND#23a, Pt. I, perMD, 6/19/07, DPS, McGertificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 11:02 P M JUNE 2007 VALDIA PAULINE CORSO /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** CLINTON PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year)
MARCH 7,1922 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1 □ M 2 💢 F LOUISIANA 85 Director 437-44-9567 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County a or 28a-f show be notified at 10a. State 1 XYes 2 No Director SUITLAND PRINCE GEORGES MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a 20746 U.S.A. 3841 ST. BARNABAS RD. UNIT T-3 by Funeral filed within 72 hours after death 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 2 XNo 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) th and Mental Hygiene.
7 is marked other than 'traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) U.S. POSTAL SERVICE CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOSEPH BARABINO UNK. and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trains 108 ESSENTON DR., UPPER MARLBORO, MD. 20774 KENNETH J. HUNT/SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-11-2007 CHAMBERS CREMATORY RIVERDALE, MD. 21. Signature of Funeral Service Live FUNERAL HOME & CREMATORIUM, P 20737 M00091 CLEVELAND AVE., RIVERDALE, MD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. HEM ch as cardiac or respiratory arrest, Immediate Cause (Final in known **Physician** disease or condition resulting in death) /Medical **FÆBRILATION** Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner certificate be executed burial-transit that initiated events and resulting in death) Last Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No The law requires that the death 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been siy Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform page 1 2 25. Was case referred to medical examiner? funeral director, 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 2 No 1 Impatient 1 🗌 Yes Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day or Attending 1 Latural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director; 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Medical

29a. Certifier

29b. Signatur

(Check only one)

30. Name and address of person

State Registrar

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manner stated.

29c. License number

29d, Date signed (Month, Dav. Year)

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		4a. Facility Name (if not institution, give			4b. Cit	ty, Town, or Lo	ocation of	Death			ounty of De		
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Funeral		5. Social Security Number 6. Se	7. Age (In yr	s. last birthday	′ <u> </u>	Jnder 1 Year	_		8. Date of B	irth (MM/DE)/YYYY) 9. Fo	. Birthplace (State preign E1	te or
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n "ng	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)			ine Op				1	rodu	0.0	I
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AD 21215-0036 2 should be filed within 72 hours after th and Montal Hygievier T's marked other than "matural", c matic event, the Me Keal Examiner.	ပ	19a. Informant's Name/Relationship (7		19b N 200	lailing Add	dress (Street ie Str	and Num eet 1	per or Ru	ural Route N	lumber, City	y or Town,	State, Zip Code	,
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e, e, l and l and Healt item		20a. Method of Disposition		Ob. Place of D	isposition or other p	(Name of central)	netery,		Date	200. L	ocation - C	ity or Town, Star	.5
DOF ages at of t: If		1 X Burial 2 Cremation 3		Family			l	6,	/29/07	E1	. Salv	ador	
Baltimore, permit. Pages 1 at Department of Het Important: If ite		4 Donation 5 Other Specify 21. Signature of Fungral Service Lice			22. Name	e and Address	of Facility	W.H.	Bacc	n Fur	eral	Home, I	nc.
Baltimore, MD 21215. permir Pages I and 2 should be filed Department of Health and Memal His Important: If item 27 is marked on injury or other traumatic event, the		Wanda C		1.361	344	7 14th	Stre	et,	N.W.	Washi	ngtor	n, D.C.	20010
Physician		23a. Part I. Enter the disease, or com-	olications that caused the c	leath. Do not e	nter the m	node of dying,	such as ca	ardiac or	respiratory	arrest, sho	ck, or heart	Approxi	mate Interval en Onset and
/Medical		failure. List only one cause on e	ach line. Head and Neck Inju										Death
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68760, certificate be ex nding physician se as the burial	₽	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcome of	fpregnancy			Ectopi	c pregna	IDCV	230	d. Date of d Month	Day	Year
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Box 687 e death certifing the attending ed for use as t	Physician	1 Yes 2 No 9 Unknow		5	Otner	(Specify)							
O. B. : the de by the ached f	함	Part II. Other significant conditions		t not resulting i	n the und	erlying cause	given in P	art I.	23e. D	id tobacco	use contrib	oute to the cause	of death?
P.O. B as that the d gned by the	ھا								1	Yes 2 ♥	No 3	Probably 4	Unknown
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Vital ysician: his certifi director,	Be C	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 🗸 ER/Out	patient 3	B DOA	Other ₄	Nursir	ng Home 5		ence 6	Other:	
∩ of \ ding Phy After th funeral of	⊢	27. Manner of Death	28a. Date of Injury		me of Inju	ıry 28c. İnji	ury at Wor		28d. Desc Pedestri	ribe how inj			
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Sic Atte r dea ecto	<u>[8</u>	2 🗸 Accident Investig	28e Place of Injury	- At home, fan	m, street,	factory, office	building, e	etc.	28f. Locati	ion (Street	and Numbe	er or Rural Route	Number, City
Division of Vital Records, spital or Attending Physician: The law requir hours after death. After this certificate has been so mental Directors. After this certificate has been so reflick in by the funeral director, page 2 should it	Certification:	3 Suicide 6 Could n		Road / Hig	hway				Viers Mill	Rd. & Sai	mpson Ro	d., Silver Sprin	g, MD
ospit hour uners	ြင်	4 Homicide 29a. Certifier 1 Certifying Phys	icing: To the best of my kr	nowledne deat	h occurre	d at the time, of	date and p	lace, and	d due to the	cause(s) a	nd manner	as stated.	
Division of Vital Records, P.O. Box 68760, Yo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The the when the speed by the attending physician and Tro the Pumeral Director: After this certificate has been signed by the attending physician and commetent filled in white finneral director, page 2 should be detached for use as the burial - transit	Medical	(Check only cone) 2 Medical Examin	er:On the basis of examin	ation and/or in	vestigatio	n, in my opinio	on, death o	ccurred	at the time,	date and pl	ace, and d	ue to the cause(s)
	1	29b. Signature and title of certifier	and manner stated.			29c. Licer	nse numbe	er		29d.	Date signe	ed (Month, Day,	Year)
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, DC		30. Name and address of person wh		n (Item 23a) Il Examiner	111	Penn Stre	et. Balti	more.	MD 2120	1			
		Pamela E. Southall, MD	ASSISTANT Medica				-,						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 2007 7:40 A 6 June Corona Rudolph Joseph /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel North Beach 854 Bayfront Avenue If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Feb. 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5 Social Security Number Year **Funeral** 1928 Pennsylvania 79 Director 579-28-9358 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No North Beach Directo MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 20714 854 Bayfront Avenue Funeral filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 DX'es 2 □ No 1944-If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married white 1 ☐ Yes 2 ☐No Specify Specify: altimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4or 5+) telephone installation C&P Telephone Co. Pages 1 and 2 should be filed w thent of Health and Mental Hygie tant: If Item 27 is marked other t jury or other traumatic event, th al Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (2 should be fi and Mental F is marked ot Forte Florence Amadeo Corona 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 597, North Beach, MD 20714 Elizabeth R. Corona, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or \pm 06-11-2007 | Silver Spring, MD Gate of Heaven Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility of Funeral Service Densee Rausch Funeral Home, PA Owings, MD 20736 572 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) anc Ra **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ner death certificate be executed Exami and burial-tran Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Day Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown this certificate has been signed by al director, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 22 No 3 Probably 4 ☐Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 2 No 26. Place of Death (Check only one) Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 2 ER/Outpatient 3 DOA 1 Inpatient 1 Yes 2000 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury 27. Manner of Death Certification: (Month, Day Year) Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Jonathan Lowenthal

31. Date filed (Month, Day, Year)

M.D.

2007

32. Registra Signature

110 Hospital Road #310, Prince Frederick, MD 20678

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 06 Gregory W. Covington I 09 2007 10:50 am /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2212 Round Road Apt T-2 Brooklyn Baltimore County II Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 07-14-55 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □XM 2 □ F Baltimore Director 579-72-0148 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or items 23s or 28s-f show other treumstic event, the Medical Examiner must be notified at Brooklyn Md Balitore Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2212 Round Road Apt 2 21225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 Specify þ Specify: Black 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Printing 2 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joe Covington Estelle Aquilla Daniels ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 ment of Heelth a tant: if item 27 is Gregory W. Covington II son 2212 Round Rd#T-2 Brooklyn, Md 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Depertment of Important: If it eny injury or c 1 Burial 2 Cremation 3 Removal from State Riverdale Crematory 06/18/07 Riverdale, Md 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySnead Mortuary Service, P.A. 1409 Fairlakes Pl Ste B Bowie, Md 20721 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause an each line. serand Death Immediate Cause (Final disease or condition resulting in death) ognilla **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an this certificete has ral director, page 2 1 Yes 2 No After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tes 2 No investigation 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide City or Town, State 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. 200053946 06 30. Name and address of person who completed cause of death (Item 23a) (Type-Print)

N Klamed 205 R depty Av A unopeli 21401 32. Aegistrar's Signature 31. Date filed (Month, Day, Year) State 2007 13 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 29 ESTELLE CHECKMAN-PHILIPP MAY 2007 0338AM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country)
NEW YORK Months Days 1 □ M 2 🕅 F 68 DEC 1, 1938 Director 097-30-8055 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2X No Director MD OUEEN ANNE'S STEVENSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 103 COVE CREEK COURT 21666 USA Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: WHITE <u>Ş</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) within 72 (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) COMPANY PRESIDENT MANUFACTURING 12 permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If Item 27 Is marked other I any injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be IRVING CHECKMAN GOLDIE SIEGEL ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAVID PHILIPP/HUSBAND 348 THOMPSON CREEK MALL, SUITE 302, STEVENSVILLE, MI 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 21666 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State OXFORD CEMETERY 5/30/2007 4 ☐ Donation 5 ☐ Other (Specify) OXFORD, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 Ostroush Joseph · bec 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Jun - Small Cell ue to (or as a consequence of): disease or condition resulting in death) V15 cancer /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical as the l IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a Was an autopsy page 2 2 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3□ DOA 2NO 1 🗌 Yes ij Certification: To nours after death.

neral Director: After this
y filled in by the funeral di 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of conficer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rive, Suite E Stevensville, MD 21666 115 Jall. J. Konick 32 egistrar's Signature 31. Date filed (Month, Day, Year) State JUN 0 4 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Frances Merchant Carp June 2007 11:36 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months 558-30-1141 89 May 28, 1918 Director California Usual Residence of Decedent 10a. State 10h County 10c. City. Town or Location 10d Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at Maryland 1 ☐ Yes 21 No Anne Arundel Annapolis Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8102 River Crescent Drive 21401 U.S.A. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2/€No Specify Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 5+ Psychologist Social Sciences 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Bluford Merchant Pauline Mallott ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 E. Lake Drive Annapolis, Maryland Bertram William Carp/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Lincoln Crematory 6/12/2007 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home Funeral 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cordina **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical as the l use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9☐Unknown detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>≨</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed) certificate 1□ Yes 2XNo completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ဥ 1 🔲 Inpatient To the Hospital or Attending Physwithin 24 hours after death.

To the Funeral Director: After this 28a. Date of Injury 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a, Certifie Medical nination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date sigped (Month, Day, Year) 29b. Signature and title of certifier 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pla Solmery Island Rd. Charlas Pha. MOV 139 0/0 31. Date filed (Month, Day, Year) egistrar's Signature State JUN 1 2 2007

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 06 CURLE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months M 2 F 214-48-2102 61 Feb. 18, 1946 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County or 28a-f show notified at Annapolis Anne Arundel Maryland 15€Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or items 23a or Examiner must be r 21403 U.S.A. 77 Gentry Court Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced "natural", er than "nature the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Photography Photographer event, the 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Elizabeth Jane Woelfel Thomas J. Curley, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cheryl Lynn Curley/wife 77 Gentry Court Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 6/13/2007 Davidsonville, Maryland Lakemont Mem. Gardens 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signat 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Week Physician /Medical Due to (or as a consequency of): **Examiner** eno Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 2 No certificate 1∐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After (Month, Day Year) Injury 1 Natural 2 Accident 5 | Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death

To the Funeral Director:
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours at To the Funeral E 🜠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 21438 74 . Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE HIGHWAY w strar's Signature

Registrar DHMH 17 Rev 1/2001

State

JUN 1 1 2007

31. Date filed (Month)

ORIGINAL

			1 - For State Registrar	state of Marylan		irtment of		•	giene	7 2076	0
п	Physici	an	1. Decedent's Name (First, Middle, Last) James E. Couch					2. Date of De Month	Day	3. Time of Dea	
	/Media	cal	4a. Facility Name (If not institution, give stre	et and number)		4b. City. Town	n, or Location of Deat	June h	08 200°		a ^M
	Examir	ier	Carroll Hospice Dov			West	tminster	.,		arroll	
	Funeral Director		5. Social Security Number 6. Sex 400-56-2794	7. Age (In yrs. 1	ast birthday) Yrs.	If Under 1 Ye Months Day				Birthplace (State or Fo Country) KY	oreign
	yland		10a. State 10b. County	10c. City	/, Town or Lo	cation				10d. Inside City L	Limits
	ith the Marylar or 286-1 show	ctor	MD Carroll		Westm	inster				1 ☐ Yes 2 ∑	No No
	th with the 23e or 28 ust be no	Funeral Director	10e. Street and Number 3723 Turkeyfoot Ro	əad		10f. Zip Code	21158		10g. Citizen of W US	•	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23e or 28e-1 show other treumatic event, the Modical Examiner matter multified at	b	11. Marital Status 12. 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Decedent c Yes, specify C □ Yes 2	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	specify Yes or No to Rican, etc.)	- 14. Race Black Specify:	- American Indian, k, White, etc. White	
21215-0036	filed within 72 he Hygiene. other then "natu ant, I've Modical	Completed	15. Decedent's Educati (Specify only highest grade co		(Give life. L	ent's Usual Oci kind of work do DO NOT use ret elder/Ma	ne during most of wo ired)	rking	16b. Kind of Bu	siness/Industry Lumber Co	
Maryland 2	S should be filed within and Mental Hygiene. Is markad other then sumatic event, In a M	To Be Co	17. Father's Name (First, Middle, Last) Harrison Couch					me (First, Middle,	Maiden Sumame	e)	
lary	2 should have is ma		19a. Informant's Name/Relationship (Type,	Print)			et and Number or Ri				
	1 and Health tem 27 other tr		Sharon Couch/wife 20a. Method of Disposition	20b. P	-		foot Road	and the state of t		D 21157 City or Town, State	
nor	Pages nent of I ont: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)	Oval II OIII State		sition (Name of natory or other p Crematic		872007	Hampste		
Baltimore,	permit. Pages 1 ar Department of Hes Importent: If item any injury or otha once.	I I	21. Signature of Funeral Service, Licensee	à	P	Natites of Po	enerter Honington Roa		napel, P	.A.	
			23a Fart 1. Enter the disease, or complicat shock, or heart failure. List only one of	ions that eaused the death						Approximate Interval Betwee	
	Physician		Immediate Cause (Final disease or condition resulting in death)	Laryneea	& C	nuce	1			Onset and Dea	1 <u>S</u>
1	/Medical Examiner			Due to (of as a printed)	ience of):	D. a	ccidont	- (stro	ske)	2 week	دح
	p #	iner	Sequentially list conditions, if any, Isaurig to him eductions cause. Enter Underlying Cause (Disease or injury	Duá tó (or as a consequ	aarioa of):	-					
	sician and burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequ	uence of):						
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9	ertificating physes as th	Medi	IF FEMALE:	_							
.O. Box	The law requires that the death certificate be executed tite has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medicai	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregna Other (specify)			23d. Date Mon	e of delivery ath Day Year	ır
rds, P.	w requires that been signed b should be dete	by	Part (I. Other significant conditions contrib	outing to death but not resu	ulting in the ur	derlying cause	given in Part I.	23e. Did to		bute to the cause of death	
Vital Records,		Completed							rmed? pi	Vere autopsy findings avairior to completion of causieath? Yes 2 No	ulable se of
Vita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	oital:			Othor	ath (Check only o			
of	ding Phys h. After this funeral di	n: To	27, Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of	3 DON	4 □ Nursing F njury at Vork?		dence 6 Othe now injury occurre		ce
sion	Attending I ir death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day 1 ear)	Injury		Yes 2 No	,			
Division	in Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, offic	CO CO	28f. Location (5 City or Tox		er or Rural Route Number,	,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Aedical	(Check only 2 Medical Examiner one)	an: To the best of my kno: On the basis of examinal and manner stated.	wledge, death tion and/or inv	estigation, in m	y opinion, death occu	urred at the time,	date and place, a	nd due to the cause(s)	
	V Vitt	Σ	29b. Signature and title of certifier Welleam C	Han Wi	D		onse number		29d. Date signed 6 · //	(Month, Day, Year)	
vi	13 14		30. Name and address of person who comp William C. Gran		23a) (Type,	Print) SY	rect Ba				
: •	Sta Registi	_	31. Date filed (Month, Day, Year) JUN 1 2 2007	32/Registrar's Signa		nte					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year DICK MALISE C. JUNE 6:53 AM 10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Days Yrs. MAY 24, 1935 SCOTLAND 72 229-96-5873 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 No Director PRINCE GEORGES GREENBELT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED KINGDOM 56 LAKESIDE DR. 20770 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 21X No Specify: 2 WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **ECONOMIST** WORLD BANK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DRUMMOND DICK **JENNY** COOPER 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EUGENIA KALNAY/WIFE 56 LAKESIDE DR., GREENBELT, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHAMBERS CREMATORY 6-12-2007 RIVERDALE, MD. 21. Signature of Funeral Service Line 64 ee 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 rendes M00091 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Infarction Myocardial Acute disease or condition resulting in death) Due to (or as a consequence of): Coronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tension 1 □ Yes 2 No 3 Probably 4 Unknown Completed lesterolemia 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be

marked other snould be fil. Ith and Mental Hve?

permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev

filed within 72 h I Hygiene.

Baltimore, Maryland 21215-0036

Examine the death certificate be executed

sician and burial-transit ed by the attending physician detached for use as the buria ate has been signed by page 2 should be detact To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760

Attending Physician:

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of

28c. Injury at Work? 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier Zenvom

5 ☐ Pending investigation

MD 22846

29c. License number

1 ☐ Yes 2 ☐ No

Thre 10,2007

29d. Date signed (Month, Day, Year)

39 Name and address of person who completed cause of death (Item 23a) (Type, Print)
ROBERT DIBIANCO 7901 MAPLE AND 7901 MAPLE AVE

TAKOMA PARK, MD 20912

State Registrar

Certification:

Medical

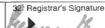
31. Date filed (Month, Day, Year) 1 2 2007 JUN

27. Manner of Death

1 Natural 2 Accident

(Check only one)

29a. Certifier



(Month, Day Year)

10

			State of Maryland / Department of Health and M 1- State Registrer Certificate of Death		ZUUT	20762
			1. Decedent's Name (First, Middle, Last)	Reg. 2. Date of Death		3. Time of Death
п	Physici			Month O	Day Year 3 2007	11:50 pM
1	/Medic Examir	- 1	Bessie Macer Dennis 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	71.00 p
	Examili	er	Cl. le Marie Con Combaide		Dorch	estep.
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.J	8. Date of Birth	9. Birth	place (State or Foreign
١.	Director		221-18-124/ 1 M 2 F 80 Yrs. Months Days Hours Min.	(Month, Day, Ye	ear) Coul	d.
	P.		Usual Residence of Decedent			Od. Inside City Limits
	arytar	L .	10a. State 10b. County 10c. City, Town or Location			1 ✓Yes 2 ☐ No
	Ba-f	octo	Md. Caroline Federalsburg			
	Mith II	듑	10e. Street and Number	10g.	. Citizen of Whal Coul	ntry ?
	23.	Funeral Director	3438 Williams St. 2/632 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spr	ecity Yes or No-	14. Race - Americ	ean Indian
	iter d	Ë	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
99	at', or	þ	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:		Specify: Bla	ck
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow the Medical Examiner must be codified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation	161	b. Kind of Business/In	dustry
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<u>yla</u>	Ment Ment Marked Marked Marked	2	James Macer Cora		ollins	
Maryland	2 should be and Mental ie marked c	1	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura		_	
	of Heelth of Heelth litem 27		Carl E. Macer, SON 3438 Williams S	t. Feder	c. Location - City or	, Md 21632
ore			1 Burial 2 Cremation 3 Removal from State			
altimore,	nit. Pag artment ortant: i njury o		4 Donation 5 Other (Specify) Chester Cem. 66-1	11-07 K	Chodesdo	ve, md.
Bai	Der min		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Fo	meralH	one	- // // -
	40140		23a. Part 1 E for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	. Hurlo	de, md.	Approximate
			shock, or head failure. List only one cause on each line.	or respiratory arrest		Interval Between Onset and Death
and the same	Physician /Medical		Immediate Causé (Final disease or condition resulting in death) a. Complications ct Diabetes			years
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		e.	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury			
Ó	exec an an rial-tr	Exa	resulting in death) Last Due to (or as a consequence of):			
8760,	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Medical	d			
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Box	th ce tendi	an/l	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of deliver Month	ery Day Year
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P.O.	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did Jobac	cco use contribute to t	he cause of death?
ds,	signe d be	d b	Hupertension, Chronic Renal Insufficiency		2 □No 3 □ Prol	
Ö	requ been shoul	ete	The state of the s	24a. Was an	24h Mara aut	nou findings qualable
Vital Records,	ug Sign	Completed	Dementia	autopsy	d? prior to co	ppsy findings available impletion of cause of
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ō	g Phy er this eral c		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how		,,
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	thin 2 the omple	Med	29b. Signature and title of certifier 29c. License number	29d	. Date signed (Month,	Day, Year)
	F 3 F 8		1/2 M/2 V.C. HECHULIST		6/5/02	
	+2		30. Name and address of person who completed cause of death (Itêm 23a) (Type, Print)	1	0/3/01	
			Usis A Narr Do. 100 Bramble Street Ca	mbride	ae MD.	21613
	Sta		31. Date filed (Month, Day, Year) 32. Segistrar's Signature) /	
	Regist	rar	JUN 0 8 2007 Strange St. James			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMENDED#1,pac,STMARYSCOUNTY,june 19,2007
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Priscilla Day **Physician** $A^{\,\mathsf{M}}$ June 18, 2007 -Percilla-9:15 Margaret Dent /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 28475 Locks Hill Road Mechanicsville St. Mary's If Under 1 Year If Under 24 Hrs.

Hours Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 1 ☐ M 2 💢 F Months 52 Maryland June 10, 1955 Director 212**-**62-0539 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lipury or other traumatic event, the Medical Examiner must be notified as once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐Yes 2X No St. Mary's Director Maryland Mechanicsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20659 USA 28475 Locks Hill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🎇 No Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodial Worker Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Margaret Lucille Spears George Hoover Dent 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 211, Chaptico, Maryland 20621 George Dent / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Bunal 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 19, 2007 Metropolitan Crematory Alexandria, Virginia 21. Sign yure of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ley thon Myocarcha **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification: To Be Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a, Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No r death. 2 Accident hours after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D54346 0 50 Gab-4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANDRA B. SAJJA, 24035 THREE NOTCH RCAD, CHANDRA B. JAJJA, 31. Date filed (Month, Day, Year) Reistrar's Signature JUN 1 9 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	ryland / I		artment rtificate			and M	ental I		ene ,, No 2 ()	07	20766
			Decedent's Name (First, Middle, Last)								2. Date o		Day	Year	3. Time of Death
	Physici /Medi		Margie Lee	Hall	Fowl	er					June	3,	2007	i bai	9:15 p ^M
	Examir		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o	f Death			4c. Count	y of Death	
			Anne Arundel Medi	cal Cente	r			apo.						Arund	del
	Funeral		Social Security Number 6. Sex	7. Age	(In yrs. last bi		If Under Months	1 Year_ Days	If Under :	24 Hrs. Min.	8. Date o (Month OCt.	f Birth , Day, Y	'ear)	Cour	place (State or Foreign
	Director		213-44-4780	3M 2017	59	Yrs.					Oct.	18,1	947	Mary	Land
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	ocation							1	Od. Inside City Limits
	Aaryli e e ho	ō	MD Anne Arun	labe	Sever	m									1 ☐ Yes 2 🛱 No
	the h	rect	10e. Street and Number	uei	bever	-11	10f. Zip	Code				100	g. Citizen of	What Cour	ntry?
	With Sa or	0	7916 Tower Court						114				U.S	5.A.	
	death ms 2	Funeral Director		12. Was Decedent E	ver in U.S.	13.	Was Deced			gin? (Spe	cify Yes o	r No-	14. Ra	ice - Americ	
ယ	after and a second	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 N	0		_	_		i, Puerto	Hican, etc.	.)		ack, White,	
9	ours a	l by	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give 22 Year or Dates:			1 ☐ Yes 2	2X) 140	Specify:				Speci	ity: whi	ice
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23s or 28s-f ehow he Wadical Exeminer must be multied at	Completed	15. Decedent's Edu (Specify only highest grade		16a	(Give	dent's Usua kind of wor	k done d	during most	t of worki	ing	16	8b. Kind of E	Business/In	dustry
21	of thin	ig.	Elementary/Secondary (0-12)	College (1-4or 5	+)		DO NOT us)				h		
7	lied v dygie ther t	ပိ	12 17. Father's Name (First, Middle, Last)			ПОП	nemake	5T.	18 Mothe	r's Name	(First. Mi	ddie Ma	OWN h		
an	ntal led o	Be c		Hall					Bett		Adela			odes	
2	mark mark	ဥ	19a. Informant's Name/Relationship (Ty		198	o. Maili	ing Address	(Street a							Code)
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "naturel", or items 23a or 28a-f ehow any injury or other traumatic event, the Mudical Examiner must be notified at once.		LaDonna M. Fowler,		1 -		Howar								
<u>o</u>	F Hearlitem		20a. Method of Disposition		20b. Place o	of Dispo		ne of			Date	-	oc. Location		
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턡	mit. Dartm		21. Signature of Funeral Service License			•	2. Name an					_			
ä	Department of the partment of		Jugar /	Tub	uch	83	325 Mt	. Ha	armon	y La	ne, C	wing	gs, MI	207	736
			23a. Part 1. Enter the disease, or complesshock, or heart tailure. List only or	ications that caused	the death. Do	not en	ter the mod	e of dyin	g, such as	cardiac o	or respirato	ry arres	st,		Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition		100	50	4.4	thu	Lu	1.40	1	10	01		Onset and Death
	/Medical		resulting in death)	Due to (or as	consequence	of):	1,400	>11 VX		7		1-000			7-500
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P.O.		Physician/Med	9 Unknown	9□ Unknown											
	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant conditions con	ntributing to death bu	at not resulting	in the u	underlying c	ause give	en in Part I		23e.	Did toba	icco use co	ntribute to t	he cause of death?
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Vital		0	25. Was case refer to medical						26. Place	of Deatl	Check o				
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Sio	Attending r death. ector: After by the fune	cati	2 Accident investigation				М		Yes 2□			10			
Division	after death Director:	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc		arm, st	treet, factory	, office			28f. Locat City o	ion (Stre r Town,	et and Nun State)	nber or Run	al Route Number,
	To the Hospital or Attending Phywithin 24 hours atter death. To the Funeral Director: After thi completely filled in by the funeral		CO. C. dilina d'Esperituine Phys	nicione To the best	d any language	a dan	Aband			d alasa	and due to	the ear	100(a) and a		ntatad -
	the Hospital thin 24 hours a the Funeral i	edical		sician: To the best of ner: On the basis of and manner sta	examination a										
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	6 4 € 4		VAL DE	11/2	and		7	0	15	>5=	2	J	UNE	-4	2007
•			30. Name and address of person who co	ompleted cause of d	eath (Item 23a)	(Туре	Print)		,	_		_1_			
	1		Paul Devore, M					nap	olis,	MD	2140)3			
	St	ate	31. Date filed (Month, Day, Year)		Signature	1.		مد							

Amend# 10 E per FD 6/12/07 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AACO Health Dept lo State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** -2007 EETWOON 06 RUL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mandrin Chesapeake Hospice House Anne Arundel Harwood If Under 24 Hrs. 8. Date of Birth

Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ■ M 2 577-22-1483 83 Yrs 12/18/1923 Director Washington, D.C. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County notified at 1 ☐ Yes 2 X No Director Maryland | Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Menlarl Hygiene. Indicatorant: If them 27 is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be a 2604 Riggin Drive 21401 United States Rigging Drive Funeral Race - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ludorph A. Dohoney Ruth L. Gundling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol E. Cassidy/Daughter 11126 Country Road, Dunkirk, Maryland 20754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 06/13/2007 | Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityGeorge P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 Approximate Interval Between Onset and Death & Mowill 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** M disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4⊡Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1∐ Yes the Hospital or Attending Physician: in 24 hours after death.

the Funeral Director: After this certifica MANDRIN 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No HOSPICE 2 ER/Outpatient 3 DOA 6 Other (Specify) ၉ 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred HOUSE Certification: 1 Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) in 445 FENSE 31. Date filed (Month, Year) State Registrar

			For State OF N State Registrar	laryland / Depa <i>Cei</i>	rtificate of E			gierie Reg. No. 🥎	007	20	760
	Dhysisi		1. Decedent's Name (First, Middle, Last)				2. Date of De Month	ath Day	Year	3. Time of	Death
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г	Funeral Director		5. Social Security Number 6. Sex 1 ☐ M 2	Age (In yrs. last birthday) 49 Yrs.	Months Days	Hours Min.	(Month, Da	ıy, Year)	Cour	SH. D.	_
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936	d within 72 hours after death with the Maryland jene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceder 1 Pes 2 If Yes, Give Year or Dates	No	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 X No	n, Mexican, Puerto Specify:	Rican, etc.)	Spec	lack, White,		
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Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licenson Tornald Total	myer 1	ANZANSKY – (170 ROCKV)	OLDBERG LLE PIKI	MEMORIA E, ROCKV	AL CHAP	ELS,	INC. AND 208	852
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4	Physician		Immediate Cause (Final disease or condition	EBRAL PR						Onset and	Ar-s
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or Vital Records,	uires tha signed I d be det	l by		ia, seizui		-				bably 4 □	
Sor	w require been significant	Completed	1,5				24a. Was	an 24	h Were auto	opsy findings	available
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, to the funeral director.	Medical	29a. Certifier 1 Certifying Physician: To the beasing one) 2 Medical Examiner: On the basing one) and manner	s of examination and/or in	nvestigation, in my o	pinion, death occu	rred at the time	, date and plac	ce, and due	to the cause(s)
	o the	Mec	29b. Signature and title of certifier		29c. License	number	T	29d. Date sig	ned (Month	, Day, Year)	
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7	->		30. Name and address of person who completed cause of bt. LIBUIC HEIMZ - 173 MC/CC	of stands (them ODe) (Turns) 20g
	Sta Regist		31. Date filed (Month, Day, Year) 32 Regi	istrar's Signature	refer						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2007 June 7, 1:00 A.M Patricia Isabel Langley Greer /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 14740 Patuxent Ave. Calvert Solomons 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 08/07/1948 1 M 2 F Maryland 219-48-8617 58 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Solomons MD Director Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14740 Patuxent Ave 20688 United States items 23a Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government Contractor Quality Manager is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Marie Dilworth Robert Glenn Langley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Kelly Shields (Daughter) 46045 Warwick Dr., Lexington Park, Maryland 20653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/13/07 Our Lady Star Sea Cem. Solomons, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. P. O. Box 600, Lusby, Maryland 20657 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician OVARIAN CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine or Attending Physician; The law requires that the death certificate be executed iding physician and se as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HTW, OBESITY, GERD 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ► No 24a. Was an performed? Yes 20 No 25. Was case referred to medical Be 26. Place of Death Check onl one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No ဂ္ 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral D completely filled in the Hospital 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 36969 June 8, 2007

ID

Registrar

DHMH 17 Rev 1/2001

State

11910 H. G. Trueman Road, Lusby, Maryland 20657

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registras Signature

THE CAR

Scaria Mathew, MD
31. Date filed (Month, Day, Year)

JUN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death **Physician** Ruth G. Gruzenski 1:05P, M June 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Y If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours Months 220-07-9884 1 □ M 2 X F 86 Maryland 1921 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County a or 28a-f show be notified at Anne Arundel 1 ☐ Yes 2 No MD Pasadena Director 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code USA 8127 Woodholme Circle 21122 r than "natural", or Items 23a the Medical Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No White Specify 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) North Arundel Hospital Nurse Assistant 12 and Mental Hygi 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Unavailable Unavailable permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ex 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8129 Woodholme Circle Pasadena, MD 21122 19a. Informant's Name/Relationship (Type. Print) Dale Gruzenski/Son Place of Disposition (Name of cemetery, crematory or other place) June 11, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, MD Meadowridge Mem. Park 2007 4 Donation 5 Other (Specify) 21 Signature of Functal Service Licenses 22 Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Tes 2 ER/Outpatient 3 DOA Manner of Death Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 2 ☐ Accident (Month, Day Year Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 HOSPITA 32. Registrar's Signature 31. Date filed (Month Day, Year) State Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** VRI June 9 2007 σ0**ε:**3 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel DUNRIS Birthplace (State or Foreign Country) If Under Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 1 F Yrs. 101-24-9192 77 Jul. 4, 1929 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 □Yes 2 No Annapolis Anne Arundel MD **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21401 800 Bestgate Road death \ permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If flem 27 is marked other the any injury or other traumany injury or other traumany. 14. Race - American Indian th and Mental Hygiene. 7 Is marked other than "naturai", or items ? traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2X No Specify: Specify: Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home LPN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Birdsall Harold Tooker ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 785 Paul Birch Drive, Crownsville, MD Priscilla Warnock/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Jun. 12, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory 2007 4 □ Donation 5 Other (Specify) Barranco & Strist, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Part 1. Enter the disease, or contributions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease r condition resulting in death) SQUAMOUS **Physician** MUNTHS /Medical CARCINOMA Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HRONIC OBSTRUCTIVE 2 □ No 3 Probably 4 Unknown Completed PISERSE 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No certificate 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 45519 Other: 4 Nursing Home 5 Residence 2 No 3□ DOA 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 6. ☐Other (Specify) Certification: To After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

100

State Registrar

JUN 12 2007

30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title certifier

31. Date filed (Month, Day,

29c. License number

29d. Date signed (Month, Day, Year)

LETERANS HIGHWAY MUERSVILLE, MO

		1 - State Registra/MEND#29dperMD6/13/07		partment of Health and Me ertificate of Death		20772 1.No.
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Examir	ner	4a. Facility Name (If not institution, give street and i	number)	4b. City, Town, or Location of Death		4c. County of Death
F		22501 Griffith Drive 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	Laytonsville	8 Date of Birth	Montgomery 9 Birthplace (State or Foreign
Funeral Director		125-30-1009 1 M 2 XF	68 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 1	(ear) 9. Birthplace (State or Foreign Country) Norway
P .		Usual Residence of Decedent	10-07-7			
shoy	2	10a. State 10b. County Md. Montgomery	10c. City, Town or	onsville		10d. Inside City Limits 1 ☐ Yes 2 X No
the N 28a-f	Director	10e. Street and Number	Bayco	10f. Zip Code	100	g. Citizen of What Country?
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or Its	y Fu	1 Never Married 2 Married 1 Tye	s 2 No Give	1 ☐ Yes 2 No Specify:	ilcari, etc./	Black, White, etc. Specify: White
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re, Maryla s 1 and 2 should f Health and Mer item 27 is marks		19a. Informant's Name/Relationship (Type, Print) Peter A. Hutchinson/Hu		iling Address (Street and Number or Rural 2501 Griffith Drive)		
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			For State Registrar	State of N	/larylan		artmen rtificat					gień Reg. Ne		20773
	Physic /Medi		Decedent's Name (First, Middle, La Margaret M. Hage								2. Date of De June	ath P	ž 200°	3. Time of Death 3:00 p м
	Exami		4a. Facility Name (If not institution, gr Sunrise Assisted		r)			Town, or Imbia	Location	of Death			County of Dead Howard	ath
Độ.	Funeral Director		171-40-0970	Sex 1 □ M 2 F 7. A	Age (In yrs. 9	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir 1075/1	913	9. Bi	rthplace (State or Foreign country)
	r 28a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Montgor	erv		y, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23e or 28e	Funeral Director	10e. Street and Number 8100 Conn Ave Apt	-			10f. Zip					10g. Ci	itizen of What C	ountry?
036	or items	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deceder Amed Forces 1 Yes 2 If Yes, Give Year or Dates	? JNo	l	Was Deced f Yes, spec	cify Cuba	ispanic Or n, Mexica Specify:	n, Puerto	ecify Yes or No Rican, etc.))•	14. Race - Am Black, Whi	ite, etc.
21215-0036	swithin 72 hours lene. rthan "naturat", the wed cal Exa	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-40)	r 5+)		dent's Usua kind of wo DO NOT us maker	rk done d se retired	ation during mos	st of worki	ng		and of Business	Andustry
Maryland 2	2 should be filed within and Mental Hygiene.	To Be C	17. Father's Name (First, Middle, Las. Joseph McGann)						_	(First, Middle, ennar	Maider	n Sumame)	
	SEE		19a. Informant's Name/Relationship John R. Hagerty/s									er, City . 2161	or Town, State,	Zip Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other trai once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ₹ 4 ☐ Donation 5 ☐ Other (Special		St.	lace of Dispo- emetery, cren Berna	rd's	Cem.		6/18,) _{ate} /2007	Mas	sachuse	
Bail	permit. Departi Importi any Inji	7)	21. Signature of Funeral Service Lice	3- Myly	M010	44 41	12 03	ld Co	olumb	ia P	ike Ell	icot		mily FH, Inc , MD 21043
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CVA Due to (or a b. Due to (or a c. Due to (or a	s a consequ s a consequ	uence of):		o or dying	y, 34011 a3	cardiac	n isophalory an			Approximate Interval Between Onset and Death 4 days
Box 68760,	death certificate be executed e ettending physician and d for use as the burial-transit	dicai	IF FEMALE: 23b. Was decedent pregnant	d23c. If yes, outcom	e of pregnar	ncy _		-		7000-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-			23d. Date of de	livery
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of Vital	ding Physicisn: Th h. After this certificate funeral director, pag	n: To Be	25. Was case referred to medical examiner? 1 Yes 2 100 27. Manner of Death	Hospital: 1 Inpat	ury	ER/Outpatient		Othe 8c. Injury Work	4 Nu	rsing Hor	(Check only one 5 Resident Res	dence	6 □Other (Spe	ocify)
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	1 Atural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be determined	e 28e. Place of Ir		Injury me, farm, stre	М	1 🗆 1	:? ∕es 2 □		28f. Location (S City or Tox	Street ar	nd Number or R	ural Route Number,
	To the Hospitel or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Properties of Certifying	nysicien: To the besininer: On the basis and manners	ot examinati	wledge, death ion and/or inv	occurred a	at the tim in my op	e, date an inion, dea	d place, a	and due to the dead at the time,	cause(s date and) and manner a d place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and trie of certifier	San	ho	m		D O	number 0 i 84	-80			te signed (Mon	
)4Ə	5		30. Name and address of person who Ronald C. Svoka	a, MD. 10	684 V	MAGE		N/C	ROFT	ON	UD 211	114		
4	Sta Registr		31. Date filed (Month, Day, Year) JUN 1 4		rar's Signat		bout							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Robert Hartshorn June 17 2007 7:37 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hospital St. Mary's <u>Leonardtown</u> If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days 1 XM 2 □ F Director 78 220-26-2503 08/03/1928 Washington, DC Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24197 Steve Uhler Road 20636 United States 14. Race -12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 👿 Married 1 ☐ Yes 2 🗓 No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electronic Engineer U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George E. Hartshorn Essie McCutheon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary D. Hartshorn/Spouse 24197 Steve Uhler Road, Hollywood, Maryland 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols Cre 06/20/2007 Charlotte Hall, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Brinsfield Funeral Home, P.A. M01206 Kyle S. Simons 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner ombour topen Sequentially list conditions cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown ivision or Vital Records. P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Whknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 14 No To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 TYes 2 TNo 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature a 29d. Date signed (Month, Day, Year) 6-18-07

100

State Registrar 30. Name and address of

31. Date filed (Month, Day, Year)

Manoj Panwala, M.D.

DHMH 17 Rev 1/2001

37767 Market Drive, Charlotte Hall, Maryland

orson wb completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \nearrow \bigcirc \bigcirc Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year SUZETTE **JENKINS** /Medical June 1042 2007 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4208 Cloudberry Court Burtonsville Montgomery 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Apr. 19 9. Birthplace (State or Foreign 1 M 2X F Year New Jersey Yrs. Director <u>146-64-6260</u> 43 ,1964 Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Burtonsville 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code items 23a or 3 10g. Citizen of What Country? 4208 Cloudberry Court 20866 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ? Is marked other than "natural", or iten traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Be Completed by 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "any Injury or other traumatic event, the Meau Since. Elementary/Secondary (0-12) College (1-4or 5+) Springbrook 10th Nursing Assistant Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Jones Toncia B. Jenkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0.866 19a. Informant's Name/Relationship (Type. Print) Tonica N. Jenkins (Daughter) 420% Cloudberry Ct., Burtonsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Buria 2 ☐ Cremation 3 ☐ Removal from State Riverdale Park Cre. 4 ☐ Dopation 5 ☐ Other (Specify) 6/12/07 Riverdale, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. leys 246 N.Washington St, Rockville, MD 20850 23a. Part1. Enter the disease, shock, or hear failure. Li complications that caused the death. o not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause Final disease or condim n resulting in death) **Physician** Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed and I-tra Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year ed by the a 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ cate has been sly, page 2 should b End Stage Renal Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 1 Yes 2 No Hospital or Attending Physiclan: 24 hours after death. funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours a **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) To the I within 2 and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D45471 6/8/07

State Registrar

DHMH 17 Rev 1/2001

12 JUN

31. Date filed (Month, Day, Year)

Yeheyis Negusyle, 1111 Spring St. Ste 214, Silver Spring, MD M.D. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

20910

-04298 -nard Thom	oc l	please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene	
onard Thom	a5 J	1. For State Contificate of Dooth	
		Registrar 2 Date of Death 3 Time of Death	
Physic edical Exan		Month Day Year 1753 hrs	
Cai Laii		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
		Easton Memorial Hospital Easton Talbot	
Eupora		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or	
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any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City	Limits
\ <u>*</u>	ال ا	md, Talbot Easton 12 Yes 2	No
rylanı a-fst		10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
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21215-00 uld be filed wit Mental Hygien marked other	event, t	Leanard Thomas Johnson Sr. Margaret Price	
	و ا و و	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Jural Route Number, City or Town, State, Zip Code)	
MD d 2 sho Ith and	traumati	Elaine Scott Johnson wife 106 meadow Dr. Apt 108, Easton, md. 2160	
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a tir	<u>r. </u>	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Buneral Home	
Balt permit. Departi	Ē	10 hold 426 Dover St. Easton Md. 2/601	
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/Medic		Immediate Cause (Final disease a, Multiple Injuries	
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of Vital Records, ng Physician: The law requir ofter this certificate has been s	tor,	25. Was case referred to medical 26. Place of Death (Check only one)	
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of ing Pl	e e	28a. Date of Injury 28b. Title of Injury 28b. Title of Injury at Work.	
Division tal or Attendi		Natural 5 Pending Jun 5, 2007 1633 hrs 1 Yes 2 No	
VIS or A after of Direc	inby	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number) or Town, State)	er, City
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director:	filled in by	1 Natural 5 Pending Investigation 2 Accident Suicide 6 Could not be determined Specify) Major Road / Highway 1633 hrs 1 Yes 2 No Driver auto auto collision Driver auto auto auto colli	
e Hos 124 h e Fur	2~1	1 293 Leftitlet	
To the To the	completely	and manner stated.	
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
+1		0.C.M.E. June 6, 2007	
+1		30. Name and address of person who completed cause of death (Item 23a)	
+1+1.		Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
	Sta		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** June 6, 2007 5:50 P Harold Eugene Johnson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pr<u>ince Frederick</u> Calvert County Calvert Memorial Hospital 5. Social Security Number If Unde Hours Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F Months Director 231-38-0406 Sept. 10. 1932 North Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Calvert County Huntingtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 420 Buckler Road 20639 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed <u>Construction</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be William Walter Johnson Estelle Maggie Pace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau 420 Buckler Road, Huntingtown, Maryland 20639 Frances E. Johnson (Wife) Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 8. 1 ☐ Burial 2 Macremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory 2007 Clinton, Maryland 21. Signature of Fu 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Lice 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** flu'c Idiona disease or condition resulting in death) /Medical Due to (ot as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off chronic death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) 4□Pregnant at time of death P.0. the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 : autopsy certificate ! 1☐ Yes 2☐ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Inpatient မ 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Directory 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Mann of Death 28b. Time of 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Division or Vital

State

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day,

(Check only one)

29b. Signature and title of certifie

and manner stated.

29c. License number

120060475

29d. Date signed (Month, Day, Year)

		ľ	For State Registrar		of Marylar	nd / Depa		Health a		ntal Hyg		007	207	80
			Decedent's Name (First, Midd	e, Last)					2	. Date of Dear	th		3. Time of	Death
	Physicia		Carrie	Rowenia	Jones					Month 05	30	2007	8:50	A ^M
	/Medic		4a. Facility Name (If not institution				4b. City, Town,	or Location of	of Death	0.5		ounty of Death		
	CXamin	lei										arolin		
			Kuxton Nurs: 5. Social Security Number	ing Home		. last birthday)	Dentor		24 Hrs. 8	Date of Birth				or Foreign
	uneral irector		219-14-4830	1 □ M 2 🔀		Yrs.	Months Days		Min.	Date of Birth (Month, Day)	Year)	Mary	place (State on try)	" T Graigit
			Usual Residence of Decedent		01				U	0-14-1	723	rial y	Tand	
land	Mo III		10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside C	ity Limits
Мал	무결	to	Maryland	Carolin			Preston					İ	1 🗌 Yes	2 N o
₽.	28a	Director	10e. Street and Number	Carorin	.е ј	1	10f. Zip Code			1	0g. Citize	en of What Cou	ntry?	
with	Sa or		4272 Jones	Lane			216	555				USA	•	
eath	18 20 Files	Funerai	11. Marital Status		Decedent Ever in 1	U.S. 13.			igin? (Speci	fv Yes or No-	14	I. Race - Amer	ican Indian.	
ler d	F F	'n	1 Never Married 2 Mai	Ame	d Forces? es 2 2 No		Was Decedent of If Yes, specify Cut	oan, Mexican	, Puerto Ri	can, etc.)		Black, White		
Is a	9 5	by	3 ☐ Widowed 4 ☐ Divorce	If Yes	, Give or Dates:		1 ☐ Yes 2 🛣 No	Specify:			S	pecify:	lack	
ž ž	ature E		15. Deceder	nt's Education		16a. Dece	dent's Usual Occu	pation			16b. Kind	d of Business/li		
filed within 72 hours efter death with the Maryland	destination of the	Completed	(Specify only highe	_ T		(Give	kind of work done DO NOT use retire	during mos ed)	t of working	7			•	
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	nda intylener and other then "natural", or liems 23a or 28a-f show event, in a Medical Exartrari mai be notified at		17. Father's Name (First, Middle	Last)				7	er's Name (First, Middle,				
should be	l and mental hygielle. Is marked other then raumatic event, the Mi	To Be	Samuel E.	Jones				Anı	nie		Gree	n		
Shou	mar mar	-	19a. Informant's Name/Relation			19b. Maili	ng Address (Stree			Route Number			D Code)	
d 2	27 Is 27 Is trau		Sharon Jone				Meteor A							21613
1 and	realth		20a. Method of Disposition	5_/_Daug		Place of Dispo	sition (Name of		Dai			ation - City or T		21015
Pages	5 2 2		1 Burial 2 Cremation				matory or other pla		06 05	2007	D		1	
j.	arment of neath and Mer ortant: If item 27 is marks injury or other traumatic 8.		* 4 □Donation 5 □ Other (21. Signature of Funeral Service		Mt		int Cemet							
permit, Pages	Department of nearth Important: If item 27 any injury or other troops			- 1 % 5	Sho	,	Name and Addr Bennie S 516 S.Ma	mith	Funera	al Home	ale Me	sevel and	21643	
	- 22		23a Par nter the disease of		at caused the des							ii y ianu	Approximat	to .
			23a. Part Enter the disease, of shock, or heart failure. Lis	only one cause	on each line.			ing, such as	cardiac or i	rospitatory att	631 ,		Interval Bet Oset and	tween
	ysician		Immediate Cause (Final disease or condition resulting in death)	_ a 4	MECH	MC	とう						Hou	.125
	ledical aminer		Todaming in accumy	Due	to (or as a conse	quence of):								
		<u>.</u>	Sequentially list conditions,	b	e to (or as a conse	augence of):								
be	S.	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	o to tor as a conse	quence or).								
ecut	and -tran	Examiner	that initiated events resulting in death) Last	c	to (or as a conse	rauence of):								
e be executed	siclen and burial-transit	calE			710 (01 45 4 55/155	iqualito ory.								
	attending physic d for use as the b			d										
> C	ding se as	Physician/Med	IF FEMALE:	23c If yes	, outcome of pregr	nancy								
atho	for us	ian	23b. Was decedent pregnant in the past 12 months?	1□Li	ive birth 2 Fe	tal death 3	Ectopic pregnant	су			23	ld. Date of deli- Month	,	Year
, §	thed	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		regnant at time of Inknown	death 5L	Other (specify)							
het to	ad by detac		Part II. Other significant condit	ons contribution	to death but not re	sulting in the u	nderlying cause a	wen in Part I		23e Did to	bacco usi	e contribute to	the cause of o	death?
Physician: The law requires thet the death certificate	been signed by the attendin should be detached for use	by	DIARBYES		AL CA	-	1,	OCAL	SMID	. 1□Y			bably 4 🗆	
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N N	ast e2s	npie								24a. Was a autop:	sy	24b. Were aut prior to o	opsy findings ompletion of c	available cause of
= =	n. After this certificate has funeral director, page 2 :	Completed								perfor 1 Yes	med? 230 No	death? 1 ☐ Yes	2 No	
clan	certificate rector, pag	Be	25. Was case referred to medic examiner?						of Death (Check only or	10)			
Phyel	his c I dire	ို	1 ☐ Yes 2 No			ER/Outpatie	11 3 DOA		ursing Home	e 5 🗆 Resid	ence 6	□Other (Spec	ify)	
- G	fter t	:uo	27. Manner of Dath 1 Natural 5 □ Pend	/	ate of Injury Month, Day Year)	28b. Time o Injury		ury at ork?	28	d. Describe h	ow injury	occurred		
end l	or: A	ati	2 Accident inves	igation			M 1(]Yes 2□	No					
A	irect irect	Certification:	3 Suicide 6 Could 4 Homicide deten	nined 286. P	lace of Injury - At uilding, etc. (Spec	home, farm, st	reet, factory, office	•	28	If. Location (S City or Tow		Number or Ru	ral Route Nuπ	nber,
To the Hospital or Attending	within 24 hours arter death. To the Funeral Director: A completely filled in by the fu	Ç												
de0	une une sly fil	edical	29a. Certifier Certify (Check only 2 Medica	ng Physician: To	the best of my kr he basis of examir	nowledge, deat	h occurred at the	time, date an	nd place, an	d due to the o	ause(s) a	ind manner as	stated. to the cause(s	s)
the	the F	ed	one)	and	manner stated.									
To	To	Σ	29b. Signature and title of certific		4	10		ise number	2091			signed (Month	, Day, Year)	
			March.	MU	ATTENDI	NO INT	7 76	いしとい	201	/	2.	-31-0) /	
+	-3		30. Name and address of person	who completed	cause of death (It	т 23а) (Туре,	Pri(I)	. ^ -	1.0	6,01	7			
			SLI BLE) Art	14UE	TED4	2/1251	13 15	6,00	1)	Dr. PA	al R	einbole
	Sta		31. Date filed (Month, Day, Year	2007	Registrar's Sign	natura	- Marie				- /			
	Registr	rar	00H (),	,	-	7	17							

			For State	State	of Marylar	•		lealth and i	Mental Hyg	iene	17	20701
			Registrar	41		Cei	rtificate of	Deam	2. Date of Deat	eg. No.	$\frac{1}{2} \frac{1}{2} \frac{1}$	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Las	_					Month	Day	Year	
	/Medic		Mary Louise	June			4h Cihi Town o	r Location of Death	June 13		ty of Death	12:22 a ^M
î	Examin	er	4a. Facility Name (If not institution, give		umber)			Location of Deati	1		•	
	-	100	4043 Broadbill Dr 5. Social Security Number 6. Se		7. Age (In yrs.	last birthday)	Waldorf If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Char.	9. Birthr	place (State or Foreign
	Funeral Director			□M 2 X F	95	Vre	Months Days	Hours Min.	(Month, Day, 09/07/1		Coui	ntry) n Carolina
	4		Usual Residence of Decedent						102/0//1	7+4		
	how at		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation				1	10d. Inside City Limits
	e Ma Ba-f s	용	Maryland Charles		Wa	ldorf						1 ☐ Yes 2 No
	or 24	Directo	10e. Street and Number				10f. Zip Code		1	0g. Citizen of	f What Cour	ntry?
	ath w		4043 Broadbill Dr				20603			Jnited	State	
	item:	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed F	cedent Ever in L Forces? : 2 💥 No	J.S. 13.	was Decedent of F If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	o Rican, etc.)		ack, White,	
30	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f show thet, the Medical Examiner must be notified at	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, C	aive		1 ☐ Yes 2 ☐ X No	Specify:		Spec	ify: Bla	o.l.
15-0036	tura etura		15. Decedent's Ed	ucation		16a. Dece	dent's Usual Occup	pation	- 1	16b. Kind of		
CI:	in 72 in "in Medic	Completed	(Specify only highest gra	de completed	(1-4or 5+)	(Give	kind of work done DO NOT use retire	during most of word)	king			
77.	d with giene r tha	E	8	College	(1-401 5+)	Homen	naker			Own Ho	ome	
פ	be filed stal Hygi od other event, t	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middle, I	Maiden Surna	ame)	
<u>a</u>	uld be Viental Irked o	2	James Thomas					Mary Mc	Bride			
Maryland	2 should and Men is marke aumatic		19a. Informant's Name/Relationship (Type. Print)		19b. Maili	ng Address (Street	and Number or Ru	ıral Route Numbei	r, City or Tow	n, State, Zij	Code)
_	and ealth n 27 ner tr		Elaine Young/Daug	hter_		4043	Broadbil	1 Drive,				
ore e	Pages 1 nent of H int: If Iter iny or oth		20a. Method of Disposition 1	Removal fror	n State 20b.	Place of Dispo cemetery, cre	sition (Name of matory or other pla	ce)	Date	20c. Location	1 - City or To	own, State
Ē	9 5 5		4 □ Donation 5 □ Other (Specify	1)		arles N	1emorial	Cem 06/1	8/2007 T	eonard	town,	Maryland
Baltimore,	permit. Departr Imports any inju		21. Signature of Funeral Service Licer	791		2	2. Name and Addre	ess of Facility Br:	insfield	Funera	al Hor	ne, P.A.
	007.40		Kyle S. Simons				7933 HOTT	ywood Ro	ad, Leona	aratowi	n, MD	20650 Approximate
			23a. Part1. Enter the disease, or com- shock, or heart failure. List only	one cause or	each line.		-			est,		Interval Between Onset and Death
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	/Medical Examiner		Toolaing in doubly	Due t	o (or as a conse	quence of):	M_{α}	OF lasta	515	U		
£.		-	Sequentially list conditions,		u for as a conce		11/2	Mis rue.	3,2			
	nted nsit	ü	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury		,							
,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	C. Due t	o (or as a conse	quence of):						
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9	tificat ig phy as th	edi										
Box	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant		outcome pf pregre birth 2 Fe		⊒Ectopic pregnand	ev.			Date of deliv	
	ed fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at time of		Other (specify)			'	Vionth	Day Year
P.0	ires that the de signed by the be detached t	Phy	9 ☐ Unknown Part II. Other significant conditions of			culting in the u	andarluina agusa ai	uon in Port I	220 Did to	bacco uco co	entributo to t	the cause of death?
က်	ires the signer	by	Part II. Other significant conditions of	ontributing to	death but not re	suling in the t	indenying cause gi	venin Farti.	1 □ Y			bably 4 Unknown
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Records,	ne law has b ge 2 s	Completed							24a. Was a		 b. Were autoprior to condeath? 	opsy findings available empletion of cause of
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Vita	s iciar certif	Be	25. Was case referred to medical examiner?	Hospital:	7	7500	Ot Ot	hor.	ath (Check only or			
ō	Phys r this ral di	. To	27. Monny Death		Inpatient 2 [te of Injury	ER/Outpatie	III JU DON	= 4 □ Nursing F	lome 5 X Resid			ify)
O	Attending Physician: r death. ector: After this certifics by the funeral director, I	ţi	1 Accident 5 Pending investigation	(Me	onth, Day Year)	Injury	of 28c. Inju Wo M 1	ork?]Yes 2∐No		,.,,		
Division or	or Attendatter death Director: in by the	fica	3 Suicide 6 Could not be determined	, 20e. Fla	ce of injury - At I	home, farm, st	reet, factory, office		28f. Location (S	treet and Nur	mber or Rui	ral Route Number,
ă	al or s afte al Dir	Certification:	4 Homicide	Dui	ilding, etc. (Spec	siy)			City or Tow	n, Siale)		
	Hospitai 24 hours a Funerai							time, date and plac opinion, death occ				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	fedical	one)		anner stated.							
	wit To	Σ	29b. Signature and title of certifier	L-	141.0		Zac. Licen	se number	7	29d. Date sign	ieu (Month j4	- c 7
•			A	llend	& 5 hy	24	U U	1779	/		1 1	/
			30. Name and address of person who	completed ca	at se of death (No	om 23a) (Type	Print) D. Pr	RINCE F	REDER	icic.	MD	20678
	Sta	ate	31. Date filed (Month, Day, Year)	32	. Registrar's Sigi							
Ē.	Regist	rar	JUN 1 8 2007		N A	O.C.						

		4	1 - For State Registrar	State of Ma	arylan	d / Depa <i>Cei</i>	artment tificate	of H	ealth a Death		F	Reg. No.	007	20782	
	Physici	20	1. Decedent's Name (First, Middle, Last)					2. Date of Month					O.7 Yeer	3. Time of Death	
H	Physicia /Medic Examin	al	Beatrice Krantz				Month								
b		er	4a. Facility Name (If not institution, give s Carriage Hill Nurs				4b. City, Town, or Location of Death Bethesda					4c. County of Death Montgomery			
	Funeral		Social Security Number 6. Sex	7. Ag	e (In yrs. I	last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	B. Date of Birtle Month, Day 1/23/19		9. Birth	plece (Stete or Foreign intry) Y York	
	Director		Usual Residence of Decedent												
	Maryland I ahow	tor	10a. State 10b. County 10c. City, Town or Location 10c. City, Town or Location 10c. City. Town or Location 10c. Ci					ation					10d. Inside City Limits 1 AYes 2 □ No		
	or 284	Direc	10e. Street and Number	<i>#</i> = 1.1	10f. Zip Code 1 20852							en of What Cou	•		
21215-0036	permit. Pages 1 and 2 should be lied within 72 hours after death with the maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If then Z7 is marked other then "naturel", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinar must be notified at ponce.	ral	1801 East Jefferso	2 Was Decedent Ever in U.S. 13 V			Was Decedent of Hispanic Origin? (Speci			eify Yes or No-		United States 14. Race - American Indian,			
		by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 241 If Yes, Give Year or Dates:	Armed Forces?			If Yes, specify Cuban, Mexican, Puerto Rical 1 Yes 2 No Specify:					Black, White		
		ted	15. Decedent's Edu (Specify only highest grade	ation 16a. Decec			dent's Usual Occupation kind of work done during most of working DO NOT use retired)				g	16b. Kind	nd of Business/Industry		
2	ne. hen "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) Homem								Own	wn Home		
7	ild be filed w lental Hygiel ked other ti itc event, In	ပ္ပို	17. Father's Name (First, Middle, Last)			пошеш	aker		18. Mother	r's Name	(First, Middle,				
an		To Be	David Seltzer						Flor	ence	Kerin				
Baltimore, Maryland	nd 2 shouth and N		19a. Informant's Name/Relationship (Ty David Krantz – Son								Route Numbe		Town, State, Zi 10850	ip Code)	
	of Her		20a. Method of Disposition 1 XBurial 2 Cremation 3 X	temoval from State	C	Place of Dispo	natory or o	ther place			107		ation - City or T	own, State	
ij	tment tment tant: I		' 4 □Donation 5 □ Other (Specify)		Be	th Dav				6/10.			nt, NY uneral	Direction	
Bal	Depariment Department of the sun		21. Signature of Funeral Service Licens	90		1	091 R	ockv	ille	Pike	Rockvi	ille	MD 2085	52	
· .		V 1	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death											Interval Between	
	Physician /Medical		disease or condition resulting in death)	Due to (or as		tiple uence of):	Myelo	ma						****	
	rate be executed xx hysician and immediate burial-transit and		Sequentially fist conditions,	b											
		ulne	Sequentially fist conditions, if any, leading to immediate cause. Enter Undertying Lause Disease of injury												
Ć,		Examiner	that initiated events c												
8760,	ite be iysicia ne bur	cal													
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ecords, P.O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes = 2∑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1							2.	23d. Date of delivery Month Day Year			
	res that the de signed by the a be detached f	by Ph								23e. Did t	Did tobacco use contribute to the cause of death?				
	w requires been sign should be									10	Yes 2 No 3 Probably 4 Unknown				
eco	e law re has be	Completed									24a. Was	osv	prior to c	topsy findings available completion of cause of	
E B	or Attending Physician: The ter death. Irector: After this certificate In by the funeral director, pag	Con										rmed? 2 No	death?	2 X No	
ion of Vital		Be	25. Was case referred to medical examiner?	Haenital:										n.6.1	
		To To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury at Living of 28c. Injury at Living Model?							28d. Describe how injury occurred				
		atlor	1X Natural 5 Pending 2 Accident investigation				Work? M 1 □ Yes 2 □ No			No					
Division		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					2	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospitel of within 24 hours af To the Funerel D completely filled it	Medical C													
	To th To th	Me	29b. Signature and title of certifier 29c. License number D35579								29d. Date signed (Month, Dey, Year) June 9, 2007				
,	9		Buson	on	_										
			30. Name and address of person who con Susan J. Miller M.	D 6844 Tı	ılip	Hill T		e Be	thesd	la MD	20816				
	Sta	ate	31. Date filed (Month, Day, Year)	32. Régist	rar's Signa	ature	melle	0							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June 6, 2007 10:20 a M Esther Klugherz /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Casey House If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 191 5. Social Security Numbe 6. Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2 94 19, New York Director 098-09-6609 October Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 15100 Interlachen Drive, Bldg 4, 1012 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes ŽXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) lith and Mental Hygiene. 27 is marked other than " r traumatic event, the Mer Elementary/Secondary (0-12) College (1-4or 5+) Education School Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be |Benjamin Yablon Mary Beyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Seldman-Daughter 3362 Tennyson St., NW, Washington, DC, 20015 Department of Health Important: If Item 27 any injury or other tronce. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Fort Lincoln Crematory Jun 13, 2007 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service/Licenses 22. Name and Address of Facility Simple Tribute, 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed nding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA ၉ 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

P.O. Box 68760. Records, Division or Vital To the Hospital or Attending Physician: the Funeral

> Genevieve Wroblewski, State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

MD, 32. egistrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0064615

29d. Date signed (Month, Day, Year)

6/06/2007

State of Maryland / Department of Health and Mental Hygiene State
Registra AMEND#25, 27perIME6/12/07, BWW, Moco Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month O 200 7 Keller 04 1003 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Bethesda Montgomery HOSPITA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🗷 F 141-34-0459 95 1911 Director 12 28 NY Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f shorthe Medical Examiner must be notified at Director Rockville 1 □Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? H 510 USA 20852 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 21 No ģ Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other event. permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any lightly or other traumatic event once, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Silverstein Rose Bloom 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1935 Hawthorne Avenue Alexandria VA 22311 Michael Keller - Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
New Montefiore
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 6/7/07 Pinelawn, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc 1170 Rockville Pike Rockville M852 23a. Part1. Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** 28 hours /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a considue e of: The law requires that the death certificate be executed the burial Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death regnancy 3 □Есфрі certificate has been signed by the atte rector, page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 🚾 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an PEARL autopsy performed? 2 No i or Attending Physician: after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 XYes • PF 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 060207 1627 trip 1 Tyes 2 Mo 2 Accident 3 Suicide investigation Director: the 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Montrose Rel Rodeille MD hone within 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 05 2007 D0056142 MS 30. Name and a press of person who completed cause of death (Item 23a) (Type, Print) WISCONSIN AVE STE 1530 CHEVY CHASE MO 5530 JAMES GASHO MO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 1 2 2007 JUN Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

to/100/00

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 8, 2007 Year Physician 7:55 Marion Jean Kawata Ам /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 415 Russell Avenue, #717 Gaithersburg If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 ☐ M 2 🗓 F 81 543-20-3517 May 1, 1926 Oregon Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State 1 XIYes 2 □ No Gaithersburg Maryland Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20877 United States #717 415 Russell Avenue, 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: \$ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elementary Education 5+ Educator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rachel Allen Sheldon Edward G. Sammis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 415 Russell Avenue, #717, Gaithersburg, MD 20877 Kazuyoshi Kawata (Husband) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a, Method of Disposition cemetery, crematory or o Metropolitan 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licen 10 E. Deer Park Drive, Gaithersburg, MD 20877 that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death 23a. Part1. Finter the disease, or shock, or hear follows. List complications that Immediate ause (vin-ly disease or andition Breast Cancer Physician resulting in de ith /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Liberatory in July that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Due to (or as a consequence of) physician Physician/Medical the as attending IF FEMALE 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 5 ☐ Other (specify) been signed by the s should be detached ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 s autopsy performed 1 Yes 2 No 1☐ Yes 2☑ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a Date of Injury 28c. Injury at Work? After (Month, Day Year) Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 Hospital or Attending Physician: n 24 hours after death.

e Funeral Director: Al

Baltimore, Maryland 21215-0036

6 ☐ Could not be determined

4 Homicide

(Check only one)

29a. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

TC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29b. Signature and title of certifier

D35635

29d. Date signed (Month, Day, Year) June 8, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

18111 Prince Phillip Dr., #327, Olney, Maryland 20832 Joseph Kaplan, M.D.

State Registrar

completely

within 2 the

2

Medical

31. Date filed (Month, Day, Year) 1 2 2007 JUN



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

MD_TCHD_6/4/07, pha
TCHD,6/4/07 pha

Cortificate of Death State 52, 1011, 0, 7, 7, 7, 8 State #10e, FH, TCHD, 6/4/07 Certificate of Death Amended 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month 0828 MILDRED S. KINLOCK Mai 2007 28 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Memorial Hospital Talbot taston If Under 1 Year | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** Months Days 1 □ M 2 X F Hours MARYLAND 218-16-7059 82 JUN 16,1924 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any hilpry or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1
▼Yes 2 No Director TALBOT EASTON MD 700 Port St. 10f. Zip Code 10g. Citizen of What Country? COTTAGE 336 21601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married 1 ☐ Yes 2X No Specify: 2 Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 TELEPHONE OPERATOR TELEPHONE COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FREDERICK SEITER EMMA BOSSE P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 PORT ST., COTTAGE 336, EASTON, MD 21601 WILLIAM H. KINLOCK III/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 6/1/2007 EASTON, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM
200 S. HARRISON ST., EASTON, 21. Signature of Funeral Service Licenses FUNERAL HOME PA MD 21601 JOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NNO disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Yo
9 Unknown Month 4□Pregnant at time of death 9□Unknown Year Day signed by the at 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s performed: certificate 1∐ Yes To the Hospital or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 1□ Yes 1 Inpatient 2 2 ER/Outpatient 3 DOA this funeral 27 Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 5 Pending investigation neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier me and address of person who completed cause of death (Item 23a) (Type, Print) 5 Z +10 30. Name and add 31. Date filed (Month State 2007 Registrar

		•	For State Registrar	State of Maryla		artment of rtificate o			giene Neg. No.	P. Common	207	87		
	Physicia	an	Decedent's Name (First, Middle, Last)					2. Date of Death 3. Time of Death Month Day Year						
	/Medic	al	Bernard 4a. Facility Name (If not institution, give s	R.	Kropf	elder,	Sr. , or Location of Death	6	12 4c. Cou	2007 nty of Death	6:45	Рм		
	Examin	er	113 Camelot Circle	treet and number)		Berli:				cester				
	Funeral		Social Security Number 6. Sex		. last birthday)	If Under 1 Yes	ar If Under 24 Hrs.	8. Date of Birth (Month, Day	h	9. Birthp	lace (State ontry)	or Foreign		
24	Director		219-26-2943	M 2□F 6	8 Yrs.			7-6-19		Mar	yland			
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0 KIKI 3-0030		ctor	MD Worcest	er	Berlin							2X No		
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7 7	filed within Hygiene. other then	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Chro	me Plat	er	_	Manu	factur	ing			
3	be file ntal Hyg d othe avent,	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	•		name)				
2	should be filed within Ind Mental Hygiene. marked other than umatic avent, the Mental Indian	P	Nicholas Kropfelder Helen Oldewurtel 19a, Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
=	d 2 sho th and I th smu trauma		Mary R. Kronfelde				Circle, B				, ,			
ע	os 1 and 3 of Health item 27		Zua. Method of Disposition	20b		osition (Name of matory or other)		Date		on - City or To	own, State			
	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 \(\) Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emovai from State	ematory	of Del	marva			ar, De	laware	5		
Dalling	permit. Page Department of Important: If any injury or once.		21. Signature of Furgeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home											
	40 = e a		23a Part Enter the disease or any	cations that caused the de			ain Street, dying, such as cardiac			faryla	Approxima	ate		
			23a. Part Enter the disease, or provincations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on one cause on each line. Immediate Cause (Final											
	hysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. TETATO COLLIGATE BY SOME Duesto (or as a consequence of): Duesto (or as a consequence of): THENOSCIENCETIC CARDIOVA SCULAR DISEASE											
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00/	ate be executed hysician and the burial-transit	cail												
200	death certificate e attending phys d for use as the		IF FEMALE:											
X Q Q	attend for use	Physician/Med								23d. Date of delivery Month Day Year d tobacco use contribute to the cause of death?				
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	w requires been sign should be		1							Yes 2.2No 3 Probably 4 Unknown				
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E E	ician: The law certificate has rector, page 2 s						00 Bl (B)	1 ☐ Yes	2 No	1 🗌 Yes	2 No			
Division of Vital	or Attending Phys after death. Director: After this in by the funeral di	To Be	25. Was case referred to medical examiner? 1 Yes 2 Ho	Hospital: 1 ☐ Inpatient 2	ath (Check only o	Residence 6 ☐Other (Specify)								
			27. Manner of Death						28d. Describe how injury occurred					
		catic	2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No					281. Location (Street and Number or Rural Route Number,					
2		Certification:	4 Homicide determined							Town, State)				
	To the Hospital within 24 hours of To the Funeral I completely filled		29a. Certifier 1☐ Certifying Phy	sician: To the best of my	(nowledge, dea	ith occurred at th	ne time, date and place	and due to the	cause(s) an	d manner as	stated.	./->		
	in 24 the Fu	Medical	one)	iner: On the basis of exam and manner stated.	ination and/or i			irred at the time,						
	To To	2	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4 13:2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 6 * 13:2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year) 6 * 13:2007											
	De	1	30. Name and address of person who d	ompleted cause of death (tem 23a) (Type	Print)	/	134		1		1115		
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		ate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	7					200			
3,30	Regist	rar	HIN 1 3 20	107 I	20 1	English 1								

DHMH 17 Rev 1/2001

ORIGINAL

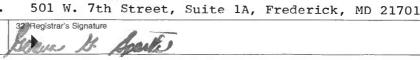
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 **Physician** Lam June 10, 2:55 p^{M} Ling /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5720 Nottingham Place Frederick Adamstown If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 🔀 F Director 568-92-9897 57 April 8, 1950 China Usual Residence of Decedent the Maryland 10c. City, Town or Location or 28a-f show e notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Directo Maryland Frederick Adamstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 must be n with 5720 Nottingham Place 21710 USA death 1 Funeral Items 2 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iter any Injury or other traumatic event, the Medical Examines once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify δ Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Entry Settlement Firm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Min Chu Kam Yuk Wong 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ki Ho Lam/Husband 5720 Nottingham Place, Adamstown, MD 21710 Date 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other planklawn Memorial June ★ Burial 2 Cremation 3 Removal from State 16. 4 Donation 5 ☐ Other (Specify) 2007 Park Rockville, Maryland 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Increased Intracranial Pressure resulting in death) /Medical Due to (or as a consequence of): Examiner Recurrent Central Nervous System Lymphoma Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy for Month Dav Year 5 Other (specify) ed by the a ☐Yes 2156No Ö 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 🏋 No 3 ☐ Probably 4 ☐ Unknown History of Large-Cell Lymphoma Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be rector, page 2 s autopsy performed? 1 Yes Division or Vital 1☐ Yes 2 **N**0 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 1 ☐ Yes 2 🔀 No 2 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury 1 X Natural 5 Pending To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year)

State Registrar 31. Date filed (Month, Day, Year)

JUN 13 2007

Paul G. Rausch, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



June 11, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** DD P. M. James H. Leitholf /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Glen Burnie Baltimore Washington Medical Center 8. Date of Birth (Month, Day, May 9, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 X M 2 □ F 82 1925 Pennsylvania 201-14-0832 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f show 1 ☐ Yes 2 🛣 No MD Severna Park Anne Arundel must be notified Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö USA 21146 440 Bendale Drive Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 7 is marked other than "natural", or items traumatic event, the Medical Examiner mu 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 🛛 No Specify. Specify: ģ WW II 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Logistics Manager 18. Mother's Name (First, Middle, Maiden Surname) Department of Heath and Mental Hy Important: If item 27 is marked othre any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Helen E. Markey Herbert C. Leitholf 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Severna Park, MD 21146 440 Bendale Drive Helen Leitholf/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 5, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, MD Metro Crematory 4 □ Donation 5 □ Other (Specify) 2007 21. Signature of uneral Service Licensee 22. Name and Address of Facility Severna Park Funeral Home Severna Park, MD 21146 Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical or as consequence of) Examiner One bro Vascula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 2 No 1∐ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 TYes ို After this 27. Manner of Death 1 A Natural 2 Accident 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Hospital or Attending Physician: The law requires that the death certificate be executed bx 68760, Division or Vital Records, P.O. within 24 hours after death To the Funeral Director:

,5x1

(Check only one)

31. Date filed (Month

State

Registrar

29b. Signature and title of certified

29c. License number

29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Year) JUN 1 2 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Marian Edmunds Lobdell 2007 РМ June 9:33 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Annapolitan Anne Arundel Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🐼 F 114-18-0803 96 Director May 16, 1911 Japan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Maryland Anne Arundel Annapolis 1 ☐ Yes 2€No Director 10e. Street and Number 10f. Zin Code 10g Citizen of What Country's Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 2 84 North Old Mill Bottom Road 21409 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2**XX**No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes **XX**No þ 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Educator School System 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nelson Lyman Lobdell Leora J. Britton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is William S. Ratchford, II/executor 1039 Whitehall Cove Annapolis, Maryland 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 6 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Injury o Ft. Lincoln Crematory 6/14/2007 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Servi e License 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ONGESTIVE **Physician** resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to influed attecture. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dual to (or se a consequence of) Examiner the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as attending nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 0 in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown Ś Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 1 ☐ Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s has certificate Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 21 No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 2 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: the Hospital or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;
completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

190

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

ARVIND

31. Date filed (Month, Day, Year)

JUN 1 2 2007

DOO63145

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		ŀ	For State of Maryland / Del	ertificate of Death	, 0	ene _{J. No.} 2 0 0 7	20791
ŀ	Physicia		1. Decedent's Name (First, Middle, Last) Ruth Evangeline Lewis		2. Date of Death Month June	16 2007	3. Time of Death 6:15 P M
ř	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
		9	Solomons Nursing Center	Solomons	10 D : (D:1)		vert
	Funeral Director		5. Social Security Number 220-34-1654 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthda yrs.	Months Days Hours Min	8. Date of Birth (Month, Day, Y A Ugust 2,	(ear) 9. Birth Cou 1912 West	nplace (State or Foreign untry) Virginia
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Maryla f sho ied at	tor	West	Martinsburg		:	1 ⊠Yes 2 No
	r 28a notif	Director	Virginia Berkeley 10e. Street and Number	10f. Zip Code	10g	g. Citizen of What Cou	untry?
	th with 23a o		116 East King Street Apt. 219	25401		USA	
215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "natural", or items 23a or 28a-f show ımatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√√	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.
Ş	72 ho	ted	15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi	cedent's Usual Occupation	kina 16	6b. Kind of Business/I	ndustry
12	ithin ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of work . DO NOT use retired) Dmemaker	9	Own Home	
2	iled w Hygier Iher th nt, th		12 3 Inc		ne (First, Middle, Ma	aiden Surname)	
Maryland	d be f ental } ked of c eve	To Be	Blaine A. McCullough		•	th Newcome	r
ary	should band Ment	Ē,	19a. Informant's Name/Relationship (Type. Print) 19b. Ma	ailing Address (Street and Number or Ru	ıral Route Number, 0	City or Town, State, Z	ip Code)
	and 2 ealth a n 27 is			Santa Rosa Lane	Lusby, M		
Baltimore,	t it it			sposition (Name of prematory or other place) June	22 2007	Oc. Location - City or T	
t I	t. Pag rtment rtant:		4 □ Donation 5 □ Other (Specify) Queen's M	leadow Point Cemetery 22. Name and Address of Facility	, K	Leyser, West	virginia
g R	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee Nechael Keven Harduren	Mattingley-Gardiner F P.O. Box 270 Leonar	rdtown, MD 2	20650	
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.		or respiratory arres	it,	Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. Qvalac Hyr Due to (or as a consequence of):	ny Hymy'a			
	Examiner		Due to (or as a consequence of).	tic Cardiovasu	Jan di	Leace	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Te cg rei jo vasta			
	ecuted ind transit	Examiner	that initiated events C.				
60,	ficate be executed physician and is the burial-transit		resulting in death) Last Due to (or as a consequence of):				
58760	ficate physi s the I	edical	d				
O. Box (ath certi attending for use a	Physician/Me		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deli Month	ivery Day Year
P.0	ires that the de signed by the a i be detached		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
rds	quires n sign uld be	d by	Cardiomyopathy		1 ☐ Yes	s 2□No 3□Pro	obably 4 Unknown
Vital Records,	aw require is been sig 2 should b	Completed	congestive Heart failur	re	24a. Was an autopsy	24b. Were au	stopsy findings available completion of cause of
Ĭ	sician; The law certificate has t irector, page 2 s	mo)	Renal Insufficiency		perform	ed2/ death?	2 □ No
/ita	clan; sertific setor,	Be (25. Was case referred to medical examiner?	4.0	ath (Check only one,		
or	Physical direction	٦.	1		lome 5 ☐ Residen 28d. Describe how	nce 6 Other (Spec	cify)
O	ding h. After funer	tion	1 Natural 5 Pending (Month, Day Year) Injur		Lou. Dodding nov	rinjury occurred	
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Certification:	3 Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
	e Hospit 24 hour e Funera letely fille	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, do not be the control of the desired for the desired form. To the best of my knowledge, do not not not not not not not not not no	eath occurred at the time, date and place r investigation, in my opinion, death occu	e, and due to the cau urred at the time, da	use(s) and manner as te and place, and due	s stated. e to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Monti	h, Day, Year)
)			tuyen. c. on and	D. 5065	5	6-18-3	2007
			30. Name and address of person who completed cause of death (Item 23a) (Typ 5851 - Deale Chunch to)	De, Print) GYAN . C.	SURAN	M.D. 2	0751
	Sta		31. Date filed (Month, Day, Year) 32. degistrar's Signature	South			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 8:00 am 2007 June Jordan Meese Craig /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Country) 1 M 2 ☐ F Yrs. 53 Director 220-58-5571 April 16, 1954 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a.* show 10d. Inside City Limits 10c. City, Town or Location 10b. County r 28a-f show notified at 10a. State 1 ☐ Yes 2 No Director Silver Spring **Maryland** Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ns 23a or 3 must be n 20904 U.S.A. 13231 Betty Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian "natural", or items : 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Parts Manager **Automobile** 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 27 Is marked or traumatic ev permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evones. Dorothy Crosby Kenneth Meese ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2206 Andrews Road, Lynn Haven, Florida Alan C. Meese - Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State Fort Lincoln Crematory 6/12/2007 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Bilateral Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Wegener's Granulomatosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ner certificate be executed Exami End Stage Renal Disease resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical ding IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant atten for u 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown Herpes Zoster Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Congestive Heart Failure page 2 s has autopsy performed death? 1 ∐ Yes certificate 2 □ No Acute Myocardial Infarction 1□ Yes 2K No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ this funeral 28d. Describe how injury occurred 27. Manner of Death 28a Date of Injury 28b Time of 28c. Injury at Work? Certification: After (Month, Day Year) or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. neral Director: A 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after To the Hospital To the Funeral 1 x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier

Registrar

State

Khama ha

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Aegistrar's Signature

Baltimore, Maryland 21215-0036

Box 68760

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or Vital Records,

Division

Kshama Garg, M.D., Holy Cross Hospital, 1500 Forest Glen Road, Silver Spring, Maryland 20910

D60826

June 10, 2007

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death Day **Physician** JUNE 2007^{ear} 6 NORMAN JEFFERSON MOORE 8:45AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT WILLIAM HILL MANOR EASTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR 23 1925 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** MARYLAND 82 Yrs Director 220-16-7643 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examinar rount be notified at 10d. Inside City Limits 1 Tyles 2 □ No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 DUTCHMANS LANE 21601 USA death v Funerai permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or Homonay injury or other traumatic event are. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes X ☐ No Specify. Specify: WHITE þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATOR **EDUCATION** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARIAN REBECCA JONES ARVIE WASHINGTON MOORE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VALERINE M. KLINE/DAUGHTER 20605 FARCROFT LANE, LAYTONSVILLE, MD 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SPRING HILL CEMETERY 6/8/2007 EASTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Ruemona **Physician** 20 mil /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit the death certificate be executed Per feresur Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. à certificate has been signer rector, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 2 12 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner' Other: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification; Hospital or Attending Pl 24 hours after death. Funaral Diractor: After the 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) thin 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only othe Hr within 2 To th 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) William 30. Name and address of person who completed cause of death-(frem 23a) (Type, Print) 十以+VA WILLIAM H. WOOD, JR. M.D. 501 DUTCHMANS LANE, EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 0 7 2007 Registrar

DHMH 17 Rev 1/2001

MARION MITCHELL

Division or Vital Records, P.O. Box 68760, After this after death

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JUNE 2007 10:29PM GERTRUDE MARION MITCHELL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **EASTON** TALBOT CANDLELIGHT COVE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, MAR 14 9. Birthplace (State or Foreign Country)
MASS. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours Min. Months Days 1 □ M 2 T F 86 Director 021-16-2713 Usual Residence of Decedent death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifled at MD TALBOT EASTON 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21601 8430 INGLETON RD. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

1s marked other than "natural", or ite 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 💹 Married 1 ☐ Yes 2 X No Specify Specify: WHITE 2 3 Widowed 4 Divorced Completed 1 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY STATE GOVERNMENT 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be GERTRUDE M. COOPER CHARLES A. WATERMAN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau 8430 INGLETON RD., EASTON, MARYLAND 21601 WILLIAM MITCHELL/HUSBAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION CTR 6/11/2007 STEVENSVILLE, MD 21. Signature of Funeral Service License 22 Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Danered MA5 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-trar Due to (or as a consequence of) the attending physician Physician/Medical IF FFMALE: If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not lessulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ₽4a Was an Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence MXOther (Specify, ASSISTED 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) LIVING 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hin 24 hours at 29a. Certifier 🖅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of 14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERT B. SANCHEZ, M.D. 508 IDLEWILD AVE., EASTON, MARYLAND 21601 31. Date filed (Month, Day, Year) JUN 1 1 2007 Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			1 - For State Registrar	State of Maryland	-	ntment of Hea tificate of De			iene	20.5
	Physici	an	1. Decedent's Name (First, Middle, La Virgil Wesley					Date of Deatl	Day Yes	
	/Medic Examir		4a. Facility Name (If not institution, giv			4b. City, Town, or Lo	ocation of Death	57	4c. County of D	eath
			229 Riverview			t. Michae		Date of Bigh	Talbo	
	Funeral Director		5. Social Security Nation 6. S 213-01-8146	Sex 7. Age (In yrs. last 95	Yrs.		Hours Min.	Date of Birth (Month, Day, 11-14-	1911 E	Birthplace (State or Foreign Country) Baltimore, MC
	a-f show	ctor	10a. State 10b. County 10b Talbot		Town or Loc Mich					10d. Inside City Limits X☐ Yes 2☐ No
	th with the 23e or 28	al Director	10e. Street and Number 229 Riverview	Terrace		10f. Zip Code 21663		10	og. Citizen of What USA	Country?
036	be filed within 72 hours after death with the Maryland Ital Hygiene. to other then "natural", or Items 23s or 28s-f show event, the Modical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ŽNo If Yes, Give Year or Dates:		as Decedent of Hispa Yes, specify Cuban, M ☐ Yes 2 🂢 No S	anic Origin? (Specif Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - A Black, W Specify: W	_ 1
15-0	n 72 ho "natur	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give k	ent's Usual Occupation ind of work done during O NOT use retired)	on ing most of working	1	16b. Kind of Busine	ss/Industry
212	e filed within tl Hygiene. other then '	Somp	Elementary/Secondary (0-12) 11 years	College (1-4or 5+)		Mechanic			Self em	ployed
land	should be filed nd Mental Hygis marked other umatic event, II	To Be (17. Father's Name <i>(First, Middle, Last,</i> Henry Cecil Ma	xwell		18	Bertha Bertha	irst, Middle, M Irene	Maiden Surname) e Walter	s
Mary	ind 2 sho alth and N 27 is ma or trauma	į (5	19a. Informant's Name/Relationship (Kenneth A. Max	Type, Print) :Well (son)	19b. Mailing 932	Address (Street and Calvert	Ave., Si	Poute Number, L. Mic	City or Town, State Chaels,	Md • 21663
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should by Department of Health and Menta Important: if tiem 27 Is marked any injury or other traumatic evens.		20a. Method of Disposition 1 Burial 2 Cremation 3 1 Donation 5 Other (Special	Removal from State $ca\beta^n$	ce of Dispos 1etco 1em.	ition (Name of Cresses Car	y 6-12-	2007 [oc. Location - City Over, I	or Town, State)e •
Balt	permit. Departr Importa any inj		21. Signature of Funeral Service Licer	1 Hunless	B	Name and Address of Carrol Box	1 Hurle	y Fune	eral Hom	ne PC Md. 21663
	Physician /Medical Examiner		23a. Pert1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the death. one cause on each line. a. APPRILED Due to (or as e consequence)	SCIE	the mode of dying, s	such as cardiac or re	espiratory arre	est,	Approximate Interval Between
68760,	ifficate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence. Due to (or as a consequence						
		Med	IF FEMALE:							
P.O. Box	The law requires that the death cent ate has been signed by the attendin page 2 should be deteched for use	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal di 4 ☐ Pregnant at time of deal 9 ☐ Unknown	eath 3 E	ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ds, P.	luires that n signed b	d by PI	Part II. Other significent conditions of DIARCTES	contributing to death but not resulti	ing in the und	derlying cause given in	n Part I.	23e. Did tob		e to the cause of death? Probably 4 □Unknown
Division of Vital Records,	is a	Completed						24a. Was an autopsy perform	prior	autopsy findings available to completion of cause of ??
Vita	ticien: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		Othor	3. Place of Death (C	1		
ou of	ling Phys After this 'uneral di	lon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a Date of Injury (Month, Day Yeer)	8b. Time of Injury	28c. Injury at Work?			nce 6 □Other (S w injury occurred	(pecify)
Division	or Attend after death Director:	Certification:	2 Accident investigetion 3 Suicide 6 Could not b 4 Homicide determined	6 Ole Blace of Injune. At hom	e, farm, stree		2 □ No 28f.	Location (Str. City or Town,		Rural Route Number,
_	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical Ce	29a. Certifier (Check only one) 1 Certifying Pt 2 Medicel Exer	nysician: To the best of my knowle niner: On the basis of examination and manner stated.	edge, death on and/or inve	occurred at the time, o	date and place, and on, death occurred	I due to the ca at the time, da	use(s) and manner te and place, and c	as stated. due to the cause(s)
	To the within. To the comple	Me	29b. Signature and title of certifier	1		29c. License nu		29	d. Date signed (Mo	onth, Day, Year)
			> /Whint	/ Attendary	0-1 ====================================		57908		6/11/2	7
	ଥ		30. Name and address of person who Robert J. Patt	erson, MD 8	00 S.	Talbot	st., st	. Mich	naels, M	1d 21663
	Sta Registr		31. Date filed (Month, Day, Yeer) JUN 13	2007 Street 2	-	house				

			For	State of	Marylan				Mental Hyg	giene			
			State Registrar			Cer	tificate of	Death		Reg. No.	07	20	705
Phys	sicia	n	1. Decedent's Name (First, Middle VANE TTA	MCLE	ASE				2. Date of Dea	Day	Year	3. Time of 022	
/Me Exar	edica mine	100	4a. Facility Name (If not institutio	n, give street and num	ber)		4b. City, Town, o		ith	4c. County	of Death		
	and the last	Si ₂	Dorcheste	r Gener	al Ho	spital		nbrid		Dor			
Funer	_		5. Social Security Number 219-90-1359	6. Sex 7	7. Age (In yrs. 35	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. , (Month, Da	y, Year)	9. Birthp	olace (State on otry) SCON,	r Foreign M∂
Direct	or	-	Usual Residence of Decedent	/					10 23	1971	La:	scon,	Hu.
laryland show	0		10a. State 10b. County			y, Town or Lo					1	0d. Inside Ci	
he Ma 28a-f s		ecto	Md Talk	ot	St	. Mich	_			40	//	1X Yes	Z [] NO
th with t 23a or 2 Ist be n		al Dir	10e. Street and Number 104 Lee Stre	et			10f. Zip Code 21663			10g. Citizen of W USA	nat Cour	ntry?	
ie, way justice 2.12.13.0000 stand 2 should be filed within 72 hours after death with the Maryland filealth and Mental Hyglene. If the 27 is marked outher than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		y Funeral Director	11. Marital Status 1 X Never Married 2 Mar	If Yes, Give	es? No	'	Was Decedent of H f Yes, specify Cuba I ☐ Yes 2【XNo	ispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		k, White,		
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2 should and Me Is mark		₽ .	19a, Informant's Name/Relations						Rural Route Numbe				
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Page nent o ant: If ury or			20a. Method of Disposition ★□ Burial 2 □ Cremation 4 □ Donation 5 □ Other (5		tate Th	emetery, crep Omas N netery	natory or other plac Iemoria I	i	4-2007	St. M	icha	aels,	Мd
permit. Departi	ouce.	. 0	21. Signature of Funeral Service	Licenspe	3	R ²²			ey Fune				63
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that ca t only one cause on ea	used the deat ck line.	h. Do not ent	er the mode of dyir	ng, such as cardi	ac or respiratory ar	rrest,	l.	Approximate Interval Bet Onset and I	e ween
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.		Medical C	29a. Certifier 1 Certifyi (Check only one) 1 Medical	ng Physician: To the barrier: On the barrier: And manner	sis of examina	wledge, death	n occurred at the til vestigation, in my o	ne, date and pla ppinion, death oc	ce, and due to the curred at the time,	cause(s) and ma date and place, a	nner as s and due t	tated. o the cause(s	3)
To t withi To tl	1	Σ	29b. Signature and title of certific	M. D.			29c. Licens			29d. Date signed			
1			30. Name and address of person DAVINDLA J	ATLALL I	MM.	502	BURN	ST	CAMBRID	be no	2	1613	
	Stat	_	31. Date filed (Month, Day, Year		gistrar's Signa	ature					-		
Reg				LUUI KA	ENC. X	1 190	SOLL						

			For State Registrar	State of Ma	ıryland	I / Departmen Certificat			Mental Hy	/giene Reg. No	211	1	20797
		4	1. Decedent's Name (First, Midd	le, Last)					2. Date of D	eath			3. Time of Death
	Physici /Medic		Dixie Ann MacM	<i>l</i> urray					JUh.	e_ C	a	ear 7	6:50 M
0	Examin	er	4a. Facility Name (If not institution		\	1 1	Town, or	Location of Dea	th	1	ounty of E		\ \ \
		HI.	5. Social Security Number			st birthday) If Under	1 Year	If Under 24 Hr	S T 9 Data of B		med		ace (State or Foreign
4	Funeral Director		217–34–5457	1 M 2 M F	68	Yrs. Months	Days	Hours Mir		ay, Year	938 1	Countr	Land
×	p _i		Usual Residence of Decedent						000.	.,	750 1		
<u></u>	arylar show d at	ř	10a. State 10b. County		-	Town or Location	1					100	d. Inside City Limits
<u></u>	the M 28a-f	Director	10e. Street and Number	Arundel		everna Par				10= Ci	U 6 144b -	100	1 ☐ Yes 2 No
_	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show matic event, the Medical Examiner must be notified at	<u>=</u>	1027 Rio Lane			τοι. 21μ		146		Tug. Cil	tizen of Wha	JSA	y!
)	death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	. 13. Was Dece	dent of Hi	spanic Origin? (Specify Yes or N rto Rican, etc.)	0-	14. Race - A		
ძ ფ	s after	by Fu	1 Never Married 2 Mar	ried 1 Tes 2X N If Yes, Give	lo	1 ☐ Yes		Specify:	no riican, etc.,		Black, V Specify:	wnite, et Whit	
Morro 21215-0036	hours tural' al Ex		3 ☑ Widowed 4 ☐ Divorced	Year or Dates:		16a. Decedent's Usua	al Occupa	ation		16b K	and of Busine	ooo/Indi	Lotte :
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212	filed within Hygiene. sther than "	Com	12	College (1-401 5	+)	Presi	dent	•		Tit	le Ser	vic	es
nd /	be filed that Hygie of other event, the	Be	17. Father's Name (First, Middle, Charles Hereth						me (First, Middle th Irene				
$\Lambda_{\mathcal{A}_{\mathcal{L}}}$ Maryland	should be and Mental s marked o umatic eve	은	19a. Informant's Name/Relations			405 44-10 4-44	(0)						
	ages 1 and 2 should b nt of Health and Ment t: If item 27 is marked / or other traumatic e		Robin L. Dee/I	1 1 77		19b. Mailing Address 40 Charl					town, Sta		
∬ Baltimore,	es 1 a of Hea fitem rothe	H	20a. Method of Disposition 1 ☐ Burial 2 Cremation	2 Demoual from State	20b. Pla	ice of Disposition (Nar. metery, crematory or c	ne of ther place	e) Jur	pate 11,	20c. L	ocation - City	or Tow	n, State
ri m	Pages ment of I tant: If its jury or of	9	4 □ Donation 5 □ Other (5	Specify)	Met	tro Cremato	ory	20	07''	Ba	altimo	re,	MD
Balt	permit. Page Department o Important: If any Injury or once.		21. Signature of Furieral Service	Licensee		Barran	CO &	Sons.	P.A. Se	vern	a Park	. Fu	neral Home D 21146
			23a. Part . Enter the disease, o	r complications that caused	the death.			itchie g, such as cardia	ac or respiratory	arrest,	a Park	1	Approximate
	Physician	8 9	Immediate Cause (Final disease or condition	t only one cause on each lin	e.	. C.		ev					nterval Between Opaet and Death
	/Medical		resulting in death)	Due to (or as a	conseque		~ C-4	e V				+	6 Weeks
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		w	IF FEMALE:	1			-						
Вох	death certific attending p	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth	2 🗌 Fetal c	teath 3 Ectopic pr					23d. Date of Month	,	/ Day Year
P.O.	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Physician/M	1 ☐ Yes 2 ☑No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of dea	ath 5 ☐ Other (sp	ecify)				WOTH		oay real
م.	that I		Part II. Other significant conditi	ons contributing to death bu	t not result	ing in the underlying c	ause give	en in Part I.	23e. Did	tobacco	use contribut	e to the	cause of death?
rds	quire; en sign	ed by	Pulm	onary	8	Earph.	Se	e ha a	1)\	Yes 2	□ No 3□] Probal	bly 4 ∐Unknown
Division or Vital Records,	he law require has been sig ge 2 should b	Completed		· · · · · · · · · · · · · · · · · · ·		V		~	24a. Was		24b. Were	e autops	sy findings available
<u> </u>	sician: The certificate harector, page	Som					_	7	auto peri 1⊟ Yes	ormed? 2 X No	deat	h?	pletion of cause of □MNo
Vita	Physician: Th r this certificate ral director, pag	Be (25. Was case referred to medica examiner?				0.1		ath (Check only	one)			
or	Physical direction	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpatier 28a. Date of Injur		R/Outpatient 3 ☐ DC		4 🗆 Nursing	Home 5 ☐ Res			Specify)	
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Visi	Atter r deat ector by the	ifica	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of inju-	ry - At hom	l ne, farm, street, factory			28f. Location	Street ar	nd Number o	r Rural I	Route Number,
Ö	tal or rs afte al Dir	Certification: To	4ITOMICIOE	building, etc	. (Specify)				City or To	wn, State	9)		
	To the Hospital or Attending Physic within 24 hours after death. To the Funeral Director: After this ce completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 2 Medical	ng Physician: To the best on Examiner: On the basis of and manner state	examinatio	edge, death occurred on and/or investigation	at the tim , in my op	ne, date and plac pinion, death occ	e, and due to the curred at the time	cause(s , date an) and manne d place, and	r as stat	ted. the cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifie			290	License	number		29d. Da	te signed (M	onth, D	ay, Year)
			her	I lulert	in	P	0	747	85	3	UNE		7,2007
	15		30. Name and address of person	who completed cause of de			The	ules	وجاريا	MO	, N		Glen
	U		Baltimore	Washingto	- ·	Medical	Cei	nter	301 Ho	Ep. 7.	al Dri	1.e	Burnie
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

David Herbert Mattingly

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		Registrar		Certificate	or Dea	<i>atri</i>			Reg. I	No.		
Physicia Medical Exami		David Herbe	rt Matting	ly				Mor Jun	e of Death oth Da e 5, 2007		2151 n	
4		4a. Facility Name (if not institution Baltimore Washington	-		1	y, Town, or L n Burinie	ocation of D	eath		4c. County o		
Funeral Director		215-78-6302	6. Sex 7. Age	(In yrs. last birthday)	_	nder 1 Year nths Days	If Under 24 Hours		ate of Birth(N 5/10/1	Ī	Birthplace (State Foreign Country)	e or
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 13a or 28a-f show any natic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	10e. Street and Number 1194 Green Hol 11. Marital Status 1 Never Married 2 X Ma	Arundel ly Drive 12. Was Decedent E Armed Forces? 1 Yes 2 2 reed If Yes, Give Year or Dates: fy only highest grade comp College (1-4 or 5-4 2	No 1 letted) 16a December during	Was Dece if Yes, spe Yes dent's Usu	Zip Code 214(214(Edent of Hisp edify Cuban, 2 X No lal Occupation working life. I chandi	anic Origin? Mexican, Pu specify: on (Give kind DO NOT use	uerto Rican, d of work do e retired)	es or No- etc.)	14. Race White	JSA - American Indian, E, etc. White	2 X No
21215-0036 hould be filed within 7 and Mental Hygiene. is marked other than tric event, the Medica	To Be (Herbert Matti	ip (Type, Print)	19b. M al	ling Addre	ess (Street	Marth and Number	ha Sch	ydlow:	ski . City or Town	, State, Zip Code)	
re, M s 1 and 2 f Health i If item 2'		Doreen M. Mat 20a. Method of Disposition 1 Burial 2 X Cremation		20b. Place of Dis	oosition (Note: other pla	Name of cemo	etery,	_{Date} June 1	1,	Oc. Location -	MD 21409 City or Town, State	
Baltimore, permit. Pages 1 at Department of Het Important: If ite	2	Donation 5 Other Spore 21. Sign of a Funeral Service I		Metro C	Name a	nd Address o	of Facility Sons,	, P.A.	Seve		ore, MD rk Funera rk. MD 2	1 Home
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uted Id ransit	Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Deep venous three Due to (or as a consect c. Right ankle fracti Due to (or as a consect d. Fall	ombosis, left leg quence of): ure)							
Box 68760, re death certificate be executed the attending physician and red for use as the burial - transit	Physician/Medical	UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkr	4 Pregnant at ti	2	Fetal dea	-	Ectopic pre	egnancy		23d. Date of o	delivery Day	Year
P.O. es that the igned by the detack	ρ	Part II. Other significant condition		but not resulting in th	e underly	ing cause giv	ven in Part I.	_ L	Yes 2	2 No 3		Unknown
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ion of Vital trending Physician: leath. toor: After this certif the funeral director,	-1	27. Manner of Death 1 Natural 5 Pendi		28b. Time 0000 hrs	of Injury	28c. Injury	at Work?	Subie	escribe how ct fell	injury occurre	ed	···
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Divis To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	Medical (one) 2 Medical Exam	vsician: To the best of my niner: On the basis of exam and manner stated.		gation, in	my opinion,	death occurr		ne, date and	place, and du	ue to the cause(s)	
	Σ	29b. Signature and title of certifier) '			29c. License O.C.M				une 6, 200	d (Month, Day, Year	j
2/41		30. Name and address of person v Ana Rubio MD. Assi	vho completed cause of de stant Medical Exami	,	Street	, Baltimor	e, MD 21	201				
St Regis	ate trar	31. Date filed (Month, Day, Year) JUN 12		s Signature	Good	20						

State of Maryland / Department of Health and Mental Hygie	ne	1
Contificate of Double	1 198	40

	•	For State	State of Marylan	-	artment rtificate			nd Me		giene Reg. No.	0117	20799
	i i	Registrer 1. Decedent's Name (First, Middle, Last)							2. Date of Dea	ath	· · · · · · · · · · · · · · · · · · ·	3. Time of Death
Physicia		CLIFTON A R	THUR MCcoy	ISR.				i	Month UNE 4	, 200	7 Year	2:00 P.M
/Medica Examine	_	4a. Facility Name (If not institution, give s MANOR CARE LAI					Location of			4c. C P R	ounty of Death	EORGE
Furnant		5. Social Security Number 6. Sex		last birthday)	If Under	1 Year	If Under 2		8. Date of Birt (Month, Da	h	9. Birth	place (State or Foreign
Funeral Director		226-20-2466	M 20F 83	Yrs.	Months	Days	Hours	Min.	(Month, Day	y, Year)		GINIA
9		Usual Residence of Decedent 10a. State 10b. County	100 Cib	y, Town or Lo	antion							10d. Inside City Limits
ehow	2	10a. State 10b. County VIRGINIA NORTHUME		LLAO 1		г х7 т z						1 ☐ Yes 2 X No
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ter death with the Maryland Items 23e or 28s-f ehow net rust be nutified at	Funeral Director		12. Was Decedent Ever in U.	S. 13.	Was Deced	lent of Hi	spanic Orig	in? (Spe	ofy Yes or No		4. Race - Amer	
or Ite		1 Never Married 2 Married	Armed Forces? 1 X Yes 2 ☐ No If Yes, Give		it Yes, spec 1 □ Yes 2		Specify:	Pueno	Hican, etc.)	S	Black, White Specify: R 1	, etc. LACK
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e filed al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)		·			18. Mother	's Name	(First, Middle,	Maiden S	iumame)	
Menta Menta arked	2	HOWARD THOMPSON					DAIS	Y = E	STHER	MCcc	у	
2 should and Men is marke reumatic		19a. Informant's Name/Relationship (Ty. BETTY MCCOU DAY)			-							LBORO MD.
1 and 1 and 1 eaith 1 em 27 1 her tr	-	20a. Method of Disposition		tace of Dispo			AI VI		ate DRIVE		ation - City or 1	
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artme ortani injury		4 □ Donation 5 □ Other (Specify) 21. Supeture of Funeral Service License	/ /				s of Facility			· WAD		KGINIA
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Physician		Immediate Cause (Final disease or condition	Fallin	اسلا م	de.	$\sim \sim$	نمبر				AARTA A PAAR	Onset and Death
/Medical		resulting in death)	Due to (or as a conseq	uence of):	T							
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eath certific attending	N/UE	230. Was decedent pregnant	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta	ancy I death 3	∃Ectopic pr	egnancy				23	3d. Date of delin	,
The law requires that the death certifit ate has been signed by the attending page 2 should be detached for use as	by Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of d		Other (sp						Month	Day Year
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endir eath. or: Af	atic	2 Accident investigation			М		Yes 2□N					
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hi building, etc. (Specif	ome, farm, st fy)	reet, factory	y, office		2	28f. Location (City or To	Street and wn, State)	Number or Ru	ral Route Number,
pital ours a eral C	Ce	29a. Certifier 1 Certifying Phy	sicieл: To the best of my kno	awlodgo dool	th occurred	at the tim	no dato and	d place of	and due to the	201150(5)	and manner as	gatod
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ro the	Š	29b. Signature and title of certifier			290	c. License	e number			29d. Date	signed (Monti	n, Day, Year)
F > F 0		1 Jun	ere	MD	I	0006	2116	>		6	11310	7
()		30. Name and address of person who co	ompleted cause of death (Iter	n 23a) (Type	, Print)							
169		MEKLIT WORKNEH			POINT	C DR.	IVE C	GREE	NBELT	MAR	YLAND	20770
Stat Registra		31. Date filed (Month, Day, Year) JUN 1 3	32. Redistrar's Signa		Sand							

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE 2007 LOUISE MARSHALL 17 1:15 PMM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death CIVISTA MEDICAL CENTER CHARLES LAPLATA 8. Date of Birth (Month, Day, Year) Jan. 15,1919 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sev 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Days Hours 1 M 2 X MARYLAND 214-58-4536 88 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Charles LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20646 10200 LaPlata Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. 3 ☑ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

<u>Homemaker</u>

Baltimore, Maryland 21215-003 2

Physician

/Medical

Examiner

Directo

Funeral

ģ

Completed

Be

Elementary/Secondary (0-12)

Joseph

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

Jeanne Back/Grandaughter

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Exa

Division or Vital Records, P.O. Box 68760,

4 □ Donation 5 □ Other (Spec	Removal from State	20b. Place of Dispo cemetery, cres	matorý or othe			200 La
	494	2:	2. Name and	Address of Facility		H
23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to for as a	consequence of):	dial 1.	nfarctio		ıst,
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25. Was case referred to medical	- A.		-	26. Place of D	eath (Check only one	e)
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27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day		f 28c	. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	w
	28e. Place of injur	y - At home, farm, str (Specify)	reet, factory, o	ffice	28f. Location (Str City or Town	ee , S
(Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of and manner state	examination and/or in				
one)	diria midimion diditi					
29b. Signature and title of certifier	R. Sinds		29c. L	icense number	29	9d.
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College (1-4or 5+)

Burch

l Home, P.A. narlotte Hall, MD 20622 Approximate Interval Between Onset and Death

LOUIS

18. Mother's Name (First, Middle, Maiden Surname)

Mary Elizabeth

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

30205 Bach Drive, Charlotte Hall, MD 20622

23d. Date of delivery Month Day

Own Home

Knott

20c. Location - City or Town, State Laurel Grove, MD

Year

obacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

an psy ormed? 2V No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

idence 6 □Other (Specify)

how injury occurred

Street and Number or Rural Route Number, wn, State)

cause(s) and manner as stated. date and place, and due to the cause(s)

> 29d. Date signed (Month, Day, Year) 18th, 2007 Tune

SINDHWANI 11350 PEMBROOK SO SUITE 304 WALDORF, MD 20603 31. Date filed-(Month, Day, Year)

State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Abraham Eli Nisenfeld June 8, 2007 P^{M} 4:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Casey House Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 1 x M 2 □ F 196-24-3556 Director 74 Sept. 16, 1932Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Montgomery 1 ☐Yes 2X No Director Damascus 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 25231 Tralee Court 20872 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ဩ Yes 2 ☐ No If Yes, Give Year or Dates: 1956 1 ☐ Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 1957 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Chemical Engineer Petroleum Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Nisenfeld Blanche Katz 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther P. Nisenfeld (Wife) 25231 Tralee Court, Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, cramatory or other place) Metropolitan 20a. Method of Disposition Date 20c. Location - City or Town, State Department of himportant: If ite any injury or oft June 9, 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home, 20877 10 E. Deer Park Drive, Gaithersburg, Maryland 23a. Par 1. Enter the 7 se shick, or he into illur e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart Failure /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2⊠No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Hospice Other: 4 Nursing Home 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 5 ☐ Residence 6 ☑Other (Specify) To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 20064615 (1) June 9, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Genevieve Wroblewski, M.D., 1355 Piccard Drive, #100, Rockville, MD 20852 31. Date filed (Month, Day, Year) 32 egistrar's Signature 1 2 2007 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division or Vital Records.

			for State Registrar	State of M	iai y iai i		rtificate			iia ivie	intai i i	Reg. N	711	07	2081	02
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	and		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation		-					1	0d. Inside City	Limits
	Maryl f sho led a	ō	Marviland Ct. Ma	1 a	11.11										1 □ Yes 2	
	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Directo	Maryland St. Ma 10e. Street and Number	ry s	HOT	Lywood	10f. Zip	Code				10g. (Citizen of	What Cour	itry?	
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	ms 2	Funeral	11. Marital Status	12 Was Deceder	t Ever in U.	S. 13. ¹	Was Decedent If Yes, speci		panic Origi	in? (Specif	fy Yes or N	o-	14. Ra	State ce - Americ	an Indian,	
٥	after or Ite		1 ☐ Never Married 2 🛣 Married	Armed Forces] No		nr Yes, speci 1 □ Yes 2		, Mexican, Specify:	Риепо ни	can, etc.)			ck, White,	etc.	
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ย์	Health tem 27		20a. Method of Disposition	SETTT / WIT		ace of Dispo				Dat				- City or To		
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	/Medical		resulting in death)	Due to (or a		ience of):		~ 10	7	100	1 00	_				
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	death certificate be executed e attending physician and of for use as the burial-transit	/Me	IF FEMALE:	23c. If yes, outcom	e of progna	nev										
S O O	atten atten for us	Physician/M	23b. Was decedent pregnant in the past 12 months?	1□Live birth	2 Fetal	death 3	Ectopic pre							ite of delive onth	ery Day Ye	ar
	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	at time of ut	au SL	Other (spe	ecity)								
ŗ.	Physician: The law requires that the death certi this certificate has been signed by the attending al director, page 2 should be detached for use a		Part II. Other significant condition	s contributing to death	but not resu	Iting in the u	nderlying ca	use given	ı in Part I.		23e. Did	tobacc	o use con	tribute to th	ne cause of dea	ath?
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<u>a</u>	n: Th ficate ir, pa		OF Was seen referred to medical			· · · · · · · · · · · · · · · · · · ·					1☐ Yes	2	lo	1 ☐ Yes	2 🗆 No	
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101617	Atter deat sctor	fica	3 Suicide 6 Could no	t be 28e. Place of in	njury - At ho	me, farm, str	eet, factory,	office		281	f. Location	(Street	and Num	ber or Rura	I Route Numbe	er,
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7	ospita hours inera y fille		29a. Certifier 1 CertifyIng	Physician: To the bes	at of my know	wledge, deat	h occurred a	at the time	e, date and	place, an	d due to th	e cause	(s) and m	anner as s	tated.	
1	he Hospita n 24 hours he Funera pletely fille		29a. Certifier 1 CertifyIng (Check only one) 2 Medical Ex	Physician: To the bes kaminer: On the basis and manner:	of examinat	wledge, deat ion and/or in	n occurred a vestigation,	at the time in my opi	e, date and inion, death	l place, an h occurred	d due to th d at the time	e cause e, date a	(s) and m and place	anner as s and due to	tated. the cause(s)	
7	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical	(Check only 2 Medical Ex	kaminer: On the basis	of examinat	wledge, deat ion and/or in	vestigation,	in my opi	inion, death	h occurred	d due to th	29d. I	and place Date signe	and due to	the cause(s)	

Registrar
DHMH 17 Rev 1/2001

State

Nikkal Uppal, 24035 Three Notch Road, Hollywood, Maryland 20636
31. Date filed (Month, Day, Year)

Pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUN 1 9 2007

07-04265 Anna Orthwein 28a-f show hours after death with the Maryland or items

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2007 20803 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day June 4, 2007 1645 hrs Medical Examiner Anna Nicole Orthwein 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Shady Grove Hospital Rockville If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Days Months Hours Country) Maryland Director 07/28/1987 215-27-1231 1 M 2 X F 19 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 X Yes 2 No s 23a or 28a-f show e notified at once. Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20882 United States 10037 Banner Country Court 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married Married 2 X No Yes Specify: White f Yes, Give Year Yes 2 X No specify: Widowed Divorced other traumatic event, the Medical Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) George Washington College (1-4 or 5+) Elementary/Secondary (0-12) rmit. Pages I and 2 should be filed within 72 I spartment of Health and Mental Hygiene portant: If item 27 is marked other than friury or other traumatic event, the Medical F University Baltimore, MD 21215-0036 2 Student 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jayne Ellen Yerka William David Orthwein IV Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Father 10037 Banner Country Ct. Gaithersburg. William David Orthwein IV 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 06/16/07 Washington Rock Creek Cemetery Donation 5 Other Specify: 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave. NW Washington, DC 20016 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Enter the disease, or complicati Physician Between Onset and failure. List only one cause on each li Death **Medical** a Subarachnoid hemorrhage Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): b. Ruptured berry aneurysm, anterior communicating artery Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last B Due to (or as a consequence of): and - trans Physician/Medical **AMENDED** attending physician or use as the burial -UNPENDED The law requires that the death certificate be Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown ned by the att detached for Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 1 Yes 2 No 3 Probably 4 V Unknown <u>≨</u> σ. Completed Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? performed' ✔ Yes 2 1 🗸 Yes No this certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical of Vital Be Other₄ Hospital: 1 examiner? Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA 1 🗸 Yes ٩ 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death Certification: 1 V Natural Division 5 Pending To the Funeral Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Suicide Could not be determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 V Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 5, 2007 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner 32. Registrar's Signature 2007 Elabore . Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE Day **Physician** JEANNE O'NEILL 2007 5 11:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NATIONAL INSTITUTES 0F HEALTH **BETHESDA** MONTGOMERY Social Security Number 7. Age (In yrs. last birthday, 52 Yrs. If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) OH **Funeral** Months April 199, 6 ear) 1955 248-11-8715 Days Hours Min. Director Usual Residence of Decedent 10b County 10c. City. Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits MD Bethesda Director Montgomery 1 XYes 2 No 10f. Zip Code 20816 10e Street and Number 10g. Citizen of What Country? 6010 Woodacres Drive United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturaly, or Iten any Injury or other traumatic event, the Medical Examinar 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√ No Specify à White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+Tax Law Editor Lega1 18. Mother's Name (First, Middle, Maiden Surname)
Jeanne Schmitt 17. Father's Name (First, Middle, Last)
Francis O'Neill Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert P. Parker - Husband 6010 Woodacres Drive Bethesda MD 20816 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garden of Remembrance
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/10/07 4 Donation 5 Dother (Specify) Clarksburg, MD 21. Signature of Funeral Service Lin 22. Name and Address of FacilityEdward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852 23a. Part1. Enter the diseast, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RESPIRATORY FAILURE 2 days /Medical Due to (or as a consequence of) **Examiner** ACUTE GRAFT VERSUS HOST DISEASE 2 months Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner MULTIPLE MYELOMA 10 years burial-tran Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐Yes 2 ☐XNo 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 TInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

and

death with the Maryland

Baltimore, Maryland 21215-0036

within 24 hours a To the Funeral C To the

this

After

in by

Medical

death.

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GUCHUAN ZHU 10

29c. License number

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

MARYLAND

OH 35 083311

BETHESDA.

31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

12 2007 JUN

6 Could not be determined



and manner stated

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

CENTER DRIVE,

Rebert Wayne Odell 07-04200 UNK UNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK		State I- For State Registrar	of Maryland		rtment of tificate of			Menta	al Hyg		Reg. No	. 20	07 6	2080
Physicia	n/	 Decedent's Name (First, Middle,La 								Date of De Month	Day	Year	3. Time of 0 0842 h	
ledical Examir		Robert Wayne O' 4a. Facility Name (If not institution, gi			14	b. City, To	wn. or Lo	ocation of I		June 2, 2		c. County of Dea		
		Patuxent River-Thomas J				Solomo						St. Mary's	Calvert	
Funeral		5. Social Security Number 6. S	Sex 7. Ag	e (In yrs. la	ast birthday)	If Under		If Under 2		8. Date of B	irth(MN	//DD/YYYY) 9. E Fore	sirthplace (Stat	
Director	2	214-82-5496	XM 2_F	41	Yrs.	Months	Days	Hours	Min.	May 2	2 19	966	Country) Mai	ryland
	ļ	Usual Residence of Decedent		40- City	Town or Location	200								City Limits
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Maryland 28a-f show	횽	10e. Street and Number				10f. Zip (Code	·			10g. Ci	itizen of What Co	ountry?	
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5-00 iled wit Hygien d other		17. Father's Name (First, Middle, Las					18					en Surname)		
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shumatic event, the Medical Examiner must be notified at once	To Be	Donald E. O'Del 19a. Informant's Name/Relationship	•		19b. Mailing	Address	(Street			ane Bo		City or Town, Sta	ate, Zip Code)	
and 2 shou ealth and N tem 27 is n traumatic		Donald E. O'Dell-			1							aryland		
and and tealt tem		20a. Method of Disposition			Place of Dispos crematory or oth	ition (Nam				Date		c. Location - City		
Baltimore, permit. Pages 1 an Department of Hee Important: If ite		1 XBurial 2 Cremation 3 4 Donation 5 Other Specific			sbury ce		ry J	une 1	14,	2007	Ba	arstow M	aryland	E E
Baltime bermit. Pag Department Important: injury or ot	1	21 Signature of Funeral Service Lice			22. N	lame and A	Address o	of Facility	Raus	sch Fi	ıner	ral Home		
		23a. Part I. Enter the disease, or con	mplications that caused	the death	44(05 Br	oome	S IS	Rd rdiac or r	Por	Re	public	MD 206	76 nate Interval
Physician /Medical		failure. List only one cause on	each line.	i iio dodii	. Do not onto a		,			,,			Between	Onset and eath
kaminer		Immediate Cause (Final disease or condition resulting in death)	a. Drowning Due to (or as a cons	equence o	of):									
		Sequentially list conditions,	b											
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons c.	equence o	of):									
sit sit	xan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence (of):									
be executed sician and urial - trans	dical	X UNPENDED	d. X AMENDED											
	w i	IF FEMALE:	#4c perME	, g869,	7/2/07 T	Γ// #2	3a,27	7.28a-1	f. pe	rME,g&	9, 7	7 <u>/24/07_TT</u> 23d. Date of deliv	/ery	
Box 6876C death certificate the attending physical for use as the b	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth		2 Fe	etal death	3	Ectopic	pregnan	су		Month	Day	Year
OX (eath ce attent for use	/sici	1 Yes 2 No 9 Unknow	wn 9 Unknown	t time of a	eath 5 Ot	ther (Spec	cify)							
9 - 21		Part II. Other significant condition		th but not	resulting in the	underlying	cause gi	ven in Par	t I.	23e. Dio	tobac	co use contribute	to the cause of	of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by 1 led in by the funeral director, page 2 should be detach.	d by									1`	es 2	✓ No 3 F		
ords,	olete										topsy	prior	autopsy findir to completion	
Recol	Completed									pe 1 ✔ Ye	rformed s 2	l? death No 1 ✔		No
Vital Rec sysician: The l this certificate	Be C	25. Was case referred to medical examiner?	It to spital				1/	of Death (
f Vid Physic er this	To	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpati	ent 2	ER/Outpatient	br	Ψ, ι	y at Work?		Home 5		idence 6 🗸 0	her: Scene	
nding Ph th. After e funeral	ion:	1 Natural 5 Pending	(Month, Day,	Year)				es 2 X				ped from	oridge	
risic r Atter er dea irector	ertification:	2 Accident Investig 3 Y Suicide 6 Could n	28e Place of I		Fnd 8:0 nome, farm, stre		office bu	uilding, etc). I	28f. Location	n (Stree	et and Number or	Rural Route	lumber, City
Div	erti	3 X Suicide 6 Could n 4 Homicide determin	ned (Specific)	river								Patuxent		
To the Hosy within 24 ho To the Fun completely i	calC		sician: To the best of r	ny knowle	dge, death occu	rred at the	time, da	te and plac	ce, and c	due to the ca	ause(s)	and manner as	stated.	
Division To the Hospital or Attendii within 24 hours after death. To the Funeral Director. /	Medical	one) 2 Medical Examination Medical Examination Medical Examination 29b. Signature and title of certifier	ner:On the basis of ex and manner stated		and/or mvestiga			e number	Juniou al	ale time, de		d. Date signed		ear)
	2	250. Signature and title of certifier	010			230	O.C.N					une 3, 2007		.,
		30. Name and address of person wh	no completed cause of	death (Ite	m 23a)									
			Assistant Medica			enn Str	eet, Ba	altimore	, MD 2	1201				li li
S	tate	31. Date filed (Month Bay, Year)	2007. 32. Fi gistr	ar's Signa	ture	asto 1	,							
Regis	trar	2211 1 0	RECEIVE	Elding.	AND AND	STATE OF THE PARTY								

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1854 June 2007 Irving Pe1tz /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 **X** M 2 □ F 83 October 24,1923 New York 098-16-2334 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10c. City. Town or Location 1 ¥ Yes 2 □ No ns 23a or 28a-f sh must be notified Directo **Bethesda** Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 6609 Greyswood Road 20817 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 ☐ Divorced Caucasian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Veterans' Administration 2 Veterans' Affairs Advocate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie (Unknown) ပ Max Peltz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2402 Glenmore Terrace, Rockville, Maryland Martin Peltz - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 x Burial 2 ☐ Cremation 3 Removal from State Arlington National Cemetery Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 6/18/2007 Name and Address of Facility 21. Signature of Funeral Salvice Dicenses Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SP day S UCO /Medical Due to (or as a conse uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tran Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown ر page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy or Vital To the Hospital or Attending Physician: 25. Was ca referred to medical examiner? the fineral director, 26. Place of Death Check onl one Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 🔲 Yes 1 Inpatient this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Division 1 Vatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours are death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cept 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eric R. Brodsky, M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) Registrar's Signature State 12 2007 Registra

			For State of Ma State Registrar		artment of Healt <i>rtificate of Dea</i>		ental Hygiei _{Reg.}	(3 (3) 1 "	20807
	Physicia	on.	Decedent's Name (First, Middle, Last)					Day Year	3. Time of Death
	Physicia /Medic		Sam Y. Paek		4h Cin Town on Local	tion of Dooth	June 9, 20	4c. County of Dea	9:35 aM
	Examin	er	4a. Facility Name (If not institution, give street and number)	20	4b. City, Town, or Locat Bethese			Montgome	
opera opera opera	Funeral	Ng see	10250 West1ake Drive, Apt. #70 5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year If Ur	nder 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Bi	rthplace (State or Foreign country)
	Director		447-84-7863 1⊠ M 2□ F	82 Yrs.	Months Days Hou	urs Min.	November 29	1924	Korea
	pui "		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	ocation				10d, Inside City Limits
	Maryle f sho	ō	Maryland Montgomery		Bethesda				1 □Yes 2基 No
	r 28a-	Director	10e. Street and Number		10f. Zip Code		10g.	Citizen of What C	ountry?
	th with		10250 Westlake Drive, Apt. 702			0817		U.S.A	
٥	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at	/ Funeral	11. Marital Status 1 □ Never Married 1 □ Never Married 2 ▼ Married 1 □ Yes 2 ▼ If Yes, Give	Vo l	Was Decedent of Hispani If Yes, specify Cuban, Me 1 ☐ Yes 2xx No Spe	ic Origin? (Spe exican, Puerto ecify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
5-0036	ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education	16a Dece	dent's Usual Occupation		161	o. Kind of Busines	
ر دا د	be filed within 72 ho ntal Hygiene. of other than "natul event, the Medical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	e kind of work done during DO NOT use retired)	most of worki			
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Maryland	ould be filed wental Hygin arked other atic event, the	Be	17. Father's Name (First, Middle, Last)		18.1	viotners Name Unknov	(First, Middle, Mai wn) Yun	den Surname)	
Ž	s 1 and 2 should be f Health and Mental item 27 is marked c other traumatic eve	ြင	Kii Paek 19a. Informant's Name/Relationship (Type. Print)	19b. Mail	ing Address (Street and N			ity or Town, State,	Zip Code)
Z	and 2 sealth ar	Ш	Kyung S. Paek - Spouse	10250	Westlake Drive	e, Apt.	#702, Bethe	sda, Maryl	and 20817
altimore,	of He of He r	1 %	20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Disponentery, cre	osition (Name of ematory or other place)		Date 200	c. Location - City of	r Town, State
Ĕ	. Pages tment of tant: If it jury or o	l î	4 ☐ Donation 5 ☐ Other (Specify)	The second secon	aven Cemetery	6/12	/2007 Si	lver Spring	g, Maryland
Bal	permit. Pages Department of Important: If it any injury or conce.	k v	21. Signature of Funeral Service Licensee	Ju H	22. Name and Address of F Lines-Rinaldi F L1800 New Hamps	uneral H hire Ave	nue, Silver		
			23a, Part1. Enter the disease, or complications that caused shock or fleart failure. List only one cause on each li	the death. Do not er ne.	nter the mode of dying, su	ch as cardiac d	or respiratory arrest	1	Approximate Interval Between Onset and Death
	Physician /Medical		resulting in death)	ronic Obstruct a consequence of):	ctive Pulmonary	Disease			-
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E		ner	causa. Enter Underlying	a consequence of):					
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events c.	a consequence of):					
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687	ificate g phys	edical	d					1	
. Box	th cert ending r use a	M/ug	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant 1 □ Live birth		☐Ectopic pregnancy			23d. Date of d	elivery Day Year
О	The law requires that the death certifinate has been signed by the attending to age 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown in the past 12 months? 4 □ Pregnant a 9 □ Unknown	t time of death 5	Other (specify)			Month	Day .ou.
<u>Ч</u>	that the ed by detac	Phy	Part II. Other significant conditions contributing to death b	out not resulting in the	underlying cause given in	Part I.	23e. Did tobac	cco use contribute	to the cause of death?
g	quires n sign ald be	d by					1 ▼ Yes	2 No 3	Probably 4 □Unknown
Records, P.	aw rec is bee 2 shou	Completed					24a. Was an autopsy	24b. Were	autopsy findings available o completion of cause of
Ě	The law ate has page 2	Com					performe		?
Vita	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?		Other:		h Check onl one		
	Phys r this c	5 -	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpation 27. Manner of Death 28a. Date of Inju	ury 28b. Time	of 28c. Injury at		ome 5 A Residence 28d. Describe how		pecify)
o	Attending Ir death.	atlon	1 ☑ Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	ay Year) Injury	M 1 ☐ Yes	2 □ No			
Division or	l or Attendate er deatt Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of in building, e	jury - At home, farm, s tc. (Specify)	street, factory, office		28f. Location (Stree City or Town,		Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours are death To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best only one) 1 Medical Examiner: On the basis on and manner standard manne	of examination and/or	ath occurred at the time, d investigation, in my opinio	late and place, on, death occur	and due to the cau	se(s) and manner e and place, and c	as stated. lue to the cause(s)
	Fo the within 2	Mec	29b. Signature and title of certifier		29c. License nur	mber	290	I. Date signed (Mo	onth, Day, Year)
)	6		Valguel Kin	NO	D40078			June	11, 2007
•	7		30. Name and address of person who completed cause of	death (Item 23a) (Type	e, Print)	This	Ti	stim.	2 Miles
			31. Date filed (Month, Day, Year) 32. The gist	trar's Signature	518. F	oce	11/2,	ND	000-
	St Regist	trar	11. Date filed (Month, Day, 1947)	we H. K	parke				

DHMH 17 Rev 1/2001

State Registrar

Peter Whotesell 31. Date filed (Month, Day, Year) JUN 1 1 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

MD, 505 A Dutchman's Ln Easton MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** June 8. 2007 /Medical Frances Julia Padgett 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County Nursing Center Prince Frederick Calvert County 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 TF Months Hours Director 87 214-12-7254 Sept. 16. 1919 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Idical Examiner must be notified at 1 ☐ Yes 2 No Director MDCalvert County Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must hem. 6250 Earl Street 20736 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Maryland State Gov't 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank J. Grabis Anna Mary Stallman ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Padgett (Son) 6250 Earl Street, Owings, Maryland 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 12. 1 Burial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Fundat Se Michael W. 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eac | line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely lifled in by the funeral director, page 2 should be detached for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes → No 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2No 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? 21 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1-Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide vithin 24 hours and
To the Funeral Dir 🕊 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifier

Jonathan D. Lowenthal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

M.D. 10 Registra Signature

DHMH 17 Rev 1/2001

29c. License number

10845 Town Center Blvd., Dunkirk, Maryland 20754

29d. Date signed (Month, Day, Year)

June 8, 2007

			For State Registrar		-		nd / Depa		t of H	ealth a	and M	lental Hy		007	20810
			Decedent's Name	(First, Middle, La	ast)							2. Date of De.	ath		3. Time of Death
	Physici		ARMAND	O R. PAN	ARIELLO							June	1 ^{Day}	2007	7:00 AM
	/Medic Examin		4a. Facility Name (If			nber)		4b. City,	Town, or	Location	of Death		4c. C	ounty of Death	
			Genesis	Health	Care -	The I	Pines		Ea	ston	1			Talbo	
	Funeral Director		5. Social Security No.	82	Sex 1X∑M 2□F	7. Age (<i>in yr</i> s. 85	last birthday) Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Bir Month Da NOV 10	⁾ . 1921	9. Birth NEW	place (State or Foreign YORK
	and		Usual Residence of 10a. State	10b. County		10c. Ci	ty, Town or Lo	ocation							10d. Inside City Limits
	Mary f sh	ō	MD	TALI	гот		EAST	'ON							¥∏Yes 2 No
	1 the	Director	10e. Street and Nun		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			10f. Zip	Code				10g. Citiz	en of What Cou	untry?
	h with		117 PAR	RRIS LANE	E. APT.	H-1			21	601				USA	
	deat	Funeral	11. Marital Status		12. Was Dece	edent Ever in U	J.S. 13.	Was Dece	dent of Hi	spanic Ori	igin? (Spe	ecify Yes or No Rican, etc.)	- 1	1. Race - Amer Black, White	
9	or Ite		_	ed 2 XMarried	1X Yes	2 🗆 No	ĺ	1 ☐ Yes				riioari, etc./			
98	ure!,	d by	3 Widowed		Year or Da	ates:								WIII	
e1	within 72 hours after death with the Maryland sne. then "neturel", or items 23s or 28s-f show the Modical Exacilinar mant be inclified at	lete		15. Decedent's E ify only highest gi	ducation ade completed)		16a. Dece (Give	dent's Usua kind of wo DO NOT us	il Occupa rk done d se retired	ation <i>during</i> mos	t of work	ing	16b. Kin	d of Business/li	ndustry
ariello 21215-0036	withi iene. then	Completed	Elementary/Secor	ndary (0-12)	College (1	-4or 5+)		ECTRO					U.S	. GOVE	RNMENT
anar Ind 21	Hygid other	BeC	17. Father's Name (First, Middle, Las	t)			1				(First, Middle,	Maiden S	lumame)	
Pa lan	Aental Mental rked c	To B	ANTHONY	PANARIEI	LLO					VIR	GINI	A ACETTA	A		
ido Pana Maryland	2 should and Mer is marks eumatic		19a. Informant's Na	me/Relationship	(Type, Print)		19b. Maili	ng Address	(Street a	and Numbe	er or Rura	al Route Numbe	er, City or	Town, State, Zi	ip Code)
nd , M	1 and 2 Health em 27 i		CHRISTIE	E ROTTMAN	N/GRANDD.)UGH			, MD	21601	
Armando imore, Ma	of He		20a. Method of Disp	osition Cremation 3 (☐Removal from 5		Place of Dispo cemetery, cre	osition (Nar matory or o	ne of ther plac	9)		Date	20c. Loc	ation - City or T	own, State
Ar	Pages ment of tant: If it jury or o			5 ☐ Other (Speci			VETERA	NS CE	METE	CRY	6/4,	/2007	HURL	OCK, MA	ARYLAND
Arman Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neture!', or items 23s or 28s-1 show any injury or other treumatic event, the Modical Examinar treat be notified at once.		21. Signature of Fu	neral Service Lice		CERO		ELLOV 2.00 S	d Addres IS, H HAR	is of Facilit IELFEI RRISO	NBEII N ST	N & NEW	NAM F	'UNERAL IARYLANI	HOME PA 21601
9	Physician /Medical Examiner	er	Immediate Cause (disease or condition resulting in death)	rtfailure. List only Final n	a. Due to (ach line.	yeurce of):			_	cardiac	or respiratory ai	rrest,		Approximate Interval Between Onset and Death
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ii ii	cien: ertific actor,	Be (25. Was case referr	red to medical						26. Place	of Death	(Check only o			
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10	0+VA	Į.	30. Name and addre	_ CROW!	TEY MI) G1	O Du	ICH m	INN'S	3 LA	NE	EA	STON	mo	21601
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			_ For	State of		nd / Depa	artment of H	lealth and I	•		•	20811
			1 - State Registrar			Ce	rtificate of l	Death		Reg. No.	.001	20011
	Physici /Medic		Daphine Yvoni						2. Date of D Month June	Death Day	2007	3. Time of Death 8:36 a M
	Examir		4a. Facility Name (If not institution	n, give street and nu	mber)			Location of Death	1	4c. 0	County of Deat	
	Funeral		636 Washington 5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	Westmi If Under 1 Year	If Under 24 Hrs.	8. Date of E	Birth		hplace (State or Foreign
166	Director		216-36-1556 Usual Residence of Decedent	1 □ M 2 □XF		66 Yrs.	Months Days	Hours Min.	July	01 194	10	DC DC
	Maryland I-f show fled at	tor	10a. State 10b. County	rrol1	10c. (City, Town or Lo	estminste	r		10d. Inside City 1 ☐ Yes		
	h with the 23a or 28a st be noti	al Director	10e. Street and Number 636 Washington	n Road			10f. Zip Code	1157		10g. Citiz	en of What Co USA	
030	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼Widowed 4 □ Divorced	ied Armed Fo	edent Ever in prces? 2 2 No ve ve ates:	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Span, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)		4. Race - Ame Black, Whit Specify:	
1215-0036	within 72 ho iene. • than "natur the Medical I	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired ietary Ai	during most of wor d)	king	Carr Cent	d of Business/ Oll HOS er	Industry Spital
and 2	al Hygie d other	Be Co	17. Father's Name (First, Middle,	Last)				18. Mother's Nam			Surname)	
ıyıa	should be nd Menta marked	은	Charles Hill 19a, Informant's Name/Relations	hip (Type. Print)		19b. Maili	ng Address (Street.		ne Wals		Trown, State, c	(in Code)
, Ma	and 2 s ealth ar m 27 is ner trau		19a. Informant's Name/Relations Amy Wyndham - I	Daughter	- Tan		ng Address (Street North Mari					
Hore	Pages 1 ent of H t: If ite ry or otl		20a. Method of Disposition Data 2 Green ation 3 Green of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 06/13/2007 20c. Location - City or Tow cemetery, crematory or other place) 06/13/2007 20c. Location - City or Tow cemetery, crematory or other place) 20c. Location - City or Tow winfield, MI 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home and Chapel, P.A.									
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l	Physician /Medical Examiner		23a Part1. Enter the disease, or complications that seased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):									Approximate Interval Between Onset and Death
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29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and til 0005924 June (2,2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Herbert V. Hen Lervon 5r. M.D. 2073 Manch Nester RU Marchester M.D.D. 2007

31. Date filed (Month, Day, Year)

JUN 1 3 2007

June 15 April

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** Thomas Crockett Patterson 2007 11:06 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5715 Emory Road Baltimore Upperco 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 1 X M 2 □ F 453-46-4120 72 Director 11/27/1934 Texas Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show items 23a or 28a-f shov ner must be notifled at 1 ☐ Yes 2 No Director Maryland Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5715 Emory Road 21155 United States Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 or i 1 ☐ Never Married 2 ☑ Married 1956 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced 1958 "natural"; Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natu 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Horse Trainer Thoroughbred Horses 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be fil Department of Health and Mental H Important: If item 27 is marked ott any Injury or other traumatic even once. Frank Patterson Grace Ollene Greer ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Lee Patterson - Wife 5715 Emory Road Upperco, Maryland 21155 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 ☐Removal from State Hampstead Cemetery 6/12/2007 Hampstead, Maryland 21. Signature of Fun ral Service Linensee 22. Name and Address of Facility Eline Funeral Home 934 South M01490 Main Street Hampstead, Maryland 21074 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) men /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed physician and ts the burial-tran Due to (or as a consequence of) P.O. Box 68760 Physician/Medical attending for use as ass IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death by the a ☐Yes 2☐No 9□Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performe page 2 certificate 2 No 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A completely filled in by the f 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 🗕 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10+1 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name a Crw 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 12 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Tenne Amend #31 per FCHD 06-14-2007 CNM Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Paul Revere Pennington June 11, 2007 9:03a. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1√M 2□F Yrs. 51 Kentucky Director August 5, 1955 402-82-7270 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County r 28a-f show notified at 1 ☑ Yes 2 ☐ No Maryland Frederick Brunswick Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 3 706 E. A Street 21716 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □XYes 2 □ If Yes, Give Year or Dates: 2 □ No white 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h, Kind of Business/Industry traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) construction Carpenter 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Ruth Marie Blue Earl Pennington ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Street, Brunswick, Maryland Charlene Pennington - wife 706 E. Α Important: If Item any Injury or othe 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State Frederick, Maryland 21701 Resthaven Memorial 6-16-2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licensee Cance 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy perform eral Director: After this certificate filled in by the funeral director, pag 1 Yes 2 No To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ inpatient 2 🔀 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 5 ☐ Pending investigation 1 M Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a To the Funeral I 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier. D47101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day

State

Registrar

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State of Maryland / Department of Health and Mental Hydiene

tephen Edwin Pe	1.	s, Jr. Stat For State egistrar	e of Maryland /		tment of ificate of		ivientai n		g. No.	07 2081
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36 hin 72 hours afte e. than "natural", edical Examiner		15. Decedent's Education (Specification (Specification) (9-12)	y only highest grade comp College (1-4 or 5			nt's Usual Occupationst of working life.			16b. Kind of Busine:	ss/industry
5-0036 led within 72 hours after thygiene. other than "natural", the Medical Examine.	Completed		2		Mecl	nanic II		E		Equiptment
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ID 21 2 should and Me 27 is ma	۴	19a. Informant's Name/Relationship Arlene Peters			19b. Mailin	g Address (Street Albany A	and Number or ve. Eas	Rural Route Num t, Walke	nber, City or Town, Stersville,	ate, Zip Code) MD 21793
6 8 8 8	ı	20a. Method of Disposition 1 Burial 2 XCremation	3 Removal from Sta	_	Place of Dispos rematory or ot	sition (Name of cem ther place)	·	Date	20c. Location - City	
Baltimore, permit. Pages 1 an Department of He Important: If ite injury or other tr		4 Donation 5 Other Spec	cify:	St		Cremator Name and Address		15/2007		ck, Maryland
Ball permit Depar Impor		21. Signature of Funeral Service Li	au: Hen						Funeral	
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Box 6876. c death certificate the attending phy and for use as the b	sicia	past 12 months? 1 Yes 2 No 9 Unkn	4 Pregnant at	time of de	-41-	ther (Specify)),
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the star death. "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Certification:	3 Suicide 6 Could	not be			eet, factory, office b	uilding, etc.	or Town.		r Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial – transi		29a. Certifier Certifying Phy	ysician: To the best of miner:On the basis of exam	v knowled	ge, death occi	urred at the time, da ation, in my opinion	ate and place, ar	nd due to the cau	se(s) and manner as	stated.
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		hing his	, mis			O.C.I	M.E.		June 13, 200	7
OHK	- 1	30. Name and address of person v	who completed cause of o							
1// 1	ŀ	Ling Li, MD Assistan	nt Medical Examine	r 111	Penn Stre	et, Baltimore,	MD 21201			

		S Amend 28b, perME, g870, 8,		Department of H Certificate of L	ealth and Mental H Death	ygiene Reg. No. 07	20815
		Decedent's Name (First, Middle, Last)			2. Date of E	Deeth Day Yeer	3. Time of Death
	Physiciar /Medica	MARGARET	JUDITH	PALMOWSKI	JUNE		7:40
	Examine	4a Fecility Name (If not institution, give stre	et end number)	4	b. City, Town, or Locetion of Dea	ath 4c. County of Death	
		9 125TH STREET			OCEAN CITY	WORCEST	
,	Funeral Director	119-30-4222	2 X F 65	birthday) If Under 1 Year Months Deys	Hours Min. 8. Date of E (Month, I		place (State or Foreign ntry) EW YORK
	and w	Usuel Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location			10d. Inside City Limits
	ath with the Marylar 23a or 28a-f ahow ust be notified at	MARYLAND WORCESTER	0	CEAN CITY			1X Yes 2 □ No
	vith the Ma	10e. Street end Number		10f. Zip Code		10g. Citizen of What Cou	ntry?
	1 wit	9 125TH STREET		21842		USA	
	r freme 23e	11. Marital Status 12.	Was Decedent Ever in U,S. Armed Forces?		spanic Origin? (Specify Yes or I n, Mexican, Puerto Rican, etc.)		
215-0036	urs a	1 Never Married 2 Merried	1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No	Specify:	Specify:	ITE
5-0	led within 72 hours lygiane. her than "natural", nt, the Medical Ex	15. Decedent's Education (Specify only highest grede co		Se. Decedent's Usual Occupa (Give kind of work done d life. DO NOT use retired)	ition luring most of working	16b. Kind of Business/Ir	ndustry
21	within ane.	Elementery/Secondary (0-12)	College (1-4or 5+)			CONCEDITOR	ON
121	Hygia ther ti	12 17. Father's Neme (First, Middle, Lest)		OFFICE MA	NAGER 18. Mother's Name <i>(First, Midd</i>	CONSTRUCT	LON
auc	should be filed within of Mantel Hygiane. marked other than imatic event, Italia		OUGHERTY		THERESA	NITSCH	
Maryland	should Man marke	19a. Informant's Name/Relationship (Type,		9b. Mailing Address (Street a	and Number or Rurel Route Num		o Code)
	1 and 2 s Health er em 27 la other trau	MARCEL PALMOWSKI/HU	SBAND	9 125TH STRE	ET, OCEAN CITY	, MARYLAND 21	.842
ē,	S = = 0	20a. Method of Disposition	20b. Place	of Disposition (Name of other), crematory or other place	Date	20c. Location - City or T	own, State
Baltimore,	permit. Pages Depertment of I Important: If Its any Injury or o	1 ☐ Burial 2 ☐ Cremation 3 ☐ Remi 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	ATORY OF DELMA	1	DELMAR DI	ELAWARE
alt	permit. Pa Depertman Important: any Injury once.	21. Signature of Fundal Service Licensee/	1/	22. Name end Addres			
Ш	80 = 9	1 Thoules IN	Haul /	HASTINGS F	UNERAL HOME, S	ELBYVILLE, DE	E. 19975
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are complicated as a complex of the compl	ons that caused the death. Dause on eech line.	o not enter the mode of dying	g, such as cardiac or respiratory	arrest,	Approximate Interval Between
	Physician					1	Onset and Death
1	/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth) e	CONGESTIV	É HEATT	FAILURE	FE	W DAYS
				a consequence of):			
	axecuted in and ial-transit	Sequentially list appditions		e consequence of):		-	20+YRS
oʻ	an an irial-tr	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury c	NA 1/12			P .	To 1-100
68760,	physician and strengit	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):			er yes
_							
Box	requiras that the death certifiens signed by the attending hould be detached for use e					1	
o.	ras that tha da signed by the a l be datached t	Part II. Other significant conditions contrib	uting to death but not resulting	g in the underlying cause give		d tobacco use contribute	
<u>α</u>	that the ded by data					□Yes 2 No 3 Pro	obably 4 Onknown
Records,	uiras th				24a. W		Vere autopsy findings vailable prior to
S					pe	c	ompletion of cause f death?
	To the Hospital or Attending Physician: The law requir within 24 hours aftar death. To the Funeral Director: After this certificata has been si completaly filled in by the funeral director, paga 2 should a shadded for the funeral director.				10	☐ Yes 2 75 440 1	□Yes 2□No
Vital	entifica ector, p	25. Was case referred to medical			26. Place of Death (Check onl	y one)	
of V	Physician: this certific ral director,	examiner? 1 No Hosp	1 Inpatient 2 ERV		4 Nursing Home 5 10-He	sidence 6 Other (Spec	ify)
0	fter th	27. Menner of Death 1 □ Naturel 5 □ Pending	(Month, Dey Year)	b. Time of UNK 28c. Injury Work	(?	e how injury occurred	
sio	Attending it death.	2 Accident investigation 3 Suicide 6 Could not be		ailon	Yes 25 No	(Street and Number or Ru	ral Pouto Number
Division	tal or Attending P rs aftar death. al Director: After t led in by the funers	4 Homicide determined	building, etc. (Specify)	, farm, street, factory, office	City or 7	Town, State)	al House Number,
	pital purs eral filled	29a. Certifier 1☐ Certifying Physicia	HICHWAY	loe, death occurred at the tim	ie, date end place, and due to the	ne ceuse(s) and manner as	stated.
	To the Hospital within 24 hours. To the Funeral completaly filled	(Check only 2 Medical Examiner: one)	On the basis of exemination and manner steted.	and/or investigation, in my op	pinion, death occurred at the tim	e, date and place, and due	to the cause(s)
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Director.	29b. Signature and title of certifier		29c. License	number	29d. Date signed (Month	, Day, Year)
	Ch >	Author C. I	South m	1 32	6241	06-11-0	7
	100	30. Neme end address person who comp	eted cause of death (Item 23	e) (Type, Print)	500 W ST SM		
	`	DOROTHY C. HO.	LELMORTH, 1	n.D. 203	SNOW ST. SN	on Hilly Ma	,21863
	State	31. Date filed (Month, Day, Year)	32. Registrer's Signature			-	
	Registra	JUN 1 3 2007	Beren H	Joanes			
DH	IMH 16 Rev 6/95			ORIGINAL			

		•	For State Registrar	State of Ma	-	epartment of Certificate of		nd Mental Hyg	iene ₂₀₀₇	20815
)	Physici /Medic Examin	al	Decedent's Name (First, Middle, La SIDON Aa. Facility Name (If not institution, give	IA R	OSEN		n, or Location of [2. Date of Dear Month JUNE	th Day Year O 9 200 7 4c. County of Dear	3. Time of Death
*	Funeral Director		Hebrew Home of 5. Social Security Number 057-07-9595 6. S		nington a (In yrs. last birtho 95 Yr	Months Da	ar If Under 24	Hrs. 8. Date of Birth (Month, Day, Nov. 18		nery thplace (State or Foreign buntry) V York
Baitimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23s or 28e-f show say injury or other treumatic avent, the Medical Examinar; ust bu multiple at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland 10e. Street and Number 401 King Farm Blv 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr. Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last 19a. Informant's Name/Relationship (Shelley Szekely, 20a. Method of Disposition 20a. Method of Disposition 21. Signature of Foreral Service Lice	rd., #202 12. Was Decedent I Amed Forces? 1 □ Yes 2 □ N If Yes, Give A Year or Dates: ducation ade completed) College (1-4or 5) Henry Red Type, Print) Daughter Semoval from State by) nsee	Lssman 19b. M 20b. Place of E compton, Wellwood	10f. Zip Cod 208 13. Was Decedent If Yes, specify Cod If Yes 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	S50 of Hispanic Origin uban, Mexican, Folio Specify: cupation ne during most original 18. Mother's Besident and Number of Blvd. olace) or Specify: cupation need during most original 18. Mother's Besident and Number of Common Blvd.	of working s Name (First, Middle, sie Gold or Rural Route Number \$\frac{\psi_202}{204}, \text{ Roc} 0 Date 6/13/07 w Funeral F	Own Hon Maiden Sumame) r, City or Town, State, Ckville MI 20c. Location - City or Pinclaum Home	ates erican Indian, le, etc. white Vindustry ae Zip Code) 20850 Town, State
760,	death certificate be executed Wedgical Examine e attending physician and dor use as the burial-transit	ical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	the death. Do not not not not not not not not not no	NIA	dying, soch as ea		igion, DC	2 Abroximate Interval Between Onset and Death
O. Box 68	death certific e attending p ed for use as f	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 Ectopic pregna	,		23d. Date of de Month	olivery Day Year
Records, P.	aw requires as been sign 2 should be	Completed by P	Part II. Other significant conditions SEIZWR	contributing to death b	ut not resulting in 1	he underlying cause	given in Part I.	23e. Did to	an 24b. Were a	utopsy findings available completion of cause of
Division of Vital Re	for Attending Physician: The later death. Director: After this certificate ha Jin by the funeral director, page	Certification: To Be Com	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Matural 5 Pending investigation 3 Suicide 6 Could not lead to the mined determined	De Shoo of Ini	y Year) 28b. Ti	ne of 28c.	Other: 4 Nurs	perfor 1 Pes of Death (Check only or sing Home 5 Resid 28d. Describe h	death? 2 DNo 1 Ye ne) lence 6 Other (Sp. low injury occurred	s 200/Alo
מ	To the Hospitel or within 24 hours after the Funeral Discompletely filled in	Medical Cer	29a. Certifier (Check only one) 29b. Signature and title of certifier Continue 1	hysician: To the best miner: On the basis o and manner st	of my knowledge, if examination and ated.	or investigation, in r	ense number	36	date and place, and du 29d. Date signed (Mon TUNE 10,	e to the cause(s) oth, Day, Year) 2-00 7
		ate rar	30. Name and address, of person who have been address, of person who have been address. Of person who have been addressed and person who have	32 Alegistr		YOR, PRINTI PONT,	EOSE RI	, ROCKVII	LE, MD	20852.

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,		Baltimore, Maryland 21215-0036	
il or Attending Physician: The law requires that the death certificate be executed after death. I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit	Physician /Medical Examiner	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.	Physici /Medic
ertification: To Be Completed by Physician/Medical Examiner		To Be Completed by Funeral Director	al
IF F 23b	imm dise resu	4a. F 2 1 Usua 10a. 11. M 13 17. F 19a (20a.	1 - 1. De 4a. F

	1 - State Registrar AMEND#5, 19 bper	FH6/13/07,E	W,McCo	Certific	ate of L	Death		Reg	I. No. 4	2081/
	1. Decedent's Name (First, Middle, Las	t)		_				Date of Death	, ^{Day} 2007 ^{Year}	3. Time of Death
n al	JAMES	E. 1	RIGGS				J	MTE 8	, = 200 /	1:05 P _M
r	4a. Facility Name (If not institution, give			4b. (City, Town, or Roc	Location of ckvil			4c. County of Death	MERY
	210 30 3310	ex 7. Ag	e (In yrs. last birth	rs. If U	nder 1 Year ths Days	If Under 24 Hours	Hrs. 8. Min. O	Date of Birth (Month, Day,) CT 29	(ear) 9. Birth (Col. Wa	pplace (State or Foreign Intry) ASh. DC
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location		· · ·				10d. Inside City Limits
CTOL	MD Monto	omery			er Spi	cinq				1 ☐ Yes 2 📉 No
a Dire	10e. Street and Number 3401 Norbec	k Road		10f	. Zip Code 2 (906		100	g. Citizen of What Cou	•
Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 ☐ If Yes, Give Year or Dates:			ecedent of Hisspecify Cuba	spanic Origi n, Mexican, Specify:	n? (Specify Puerto Ric	Yes or No- an, etc.)	14. Race - Amer Black, White Specify: Bla	, etc.
ompleted	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12th	ucation de completed) College (1-4or	5+)	(Give kind o life. DO NO	Usual Occupa If work done d OT use retired, Drive:	uring most (of working	16	Sb. Kind of Business/I Montgome Schools	•
De C	17. Father's Name (First, Middle, Last)					18. Mother'	s Name (F	irst, Middle, Ma	aiden Surname)	
0	Alvın A. Rig								Snowden	
	19a. Informant's Name/Relationship (7) 23 23		enal'ier	Aver	#5'16 ^R	oute Number, (Silve:	City or Town, State, Z	ip Code) ,MD 20906
	Clarrisse Rigg	S (MITE	20b. Place of	Disposition	(Name of	- :	Date		Oc. Location - City or	
	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Domation 5 ☐ Other (Specify		Arlin		or other place Na + 1		6/	27/47	Ft. My	er. VA
	21. Signature of Funeral Service Licen	-//	ub.	22. Nam	e and Addres	s of Facility	SNOW	DEN FU	JNERAL HO	OME, P.A. , MD 20850
	Part1. Enter the disease, or companies shock, or brant failure. List only of	olications that cause one cause on each li	d the ath. Do no	ot enter the	mode of dying	g, such as c	ardiac or re	espiratory arres	it,	Approximate Interval Between
	Immediate Carse (Final disease or condition		Liver	_						Onset and Death
	resulting in death)	Due to (or as	a consequence o							
	Sequentially list conditions,	b. Due to /or se	a consequence o	f).						
Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underhin Cause (Uisease or injury that initiated events	Due to (or as	a consequence o	17.						
EXG	resulting in death) Last	C. Due to (or as	a consequence o	f):						
25		d								
Je C	IF FEMALE:									
	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e pf pregnancy 2 Fetal death at time of death		oic pregnancy r (specify)				23d. Date of deli Month	very Day Year
Ę	Part II. Other significant conditions of	ontributing to death t	out not resulting in	the underly	ing cause give	en in Part I.		23e. Did toba	cco use contribute to	the cause of death?
0 0								1 ☐ Yes	2 No 3 Pro	obably 4 ∕∏Unknown
completed by Physician								24a. Was an autopsy perform	prior to c	topsy findings available completion of cause of
מפ	25. Was case referred to medical examiner?					26. Place of	of Death (C	check only one		
	1 Yes 2 No	Hospital: 1 ☐ Inpati	ent 2 ☐ ER/Out	patient 3[DOA Othe	4 □ Nurs	sing Home	5 ☐ Residen	ce 6 XOther (Spec	eify) Hospice
alloll:	27. Manner of Death 1 ★Natural 5 ☐ Pending 2 ☐ Accident investigation			ime of jury M	28c. Injury Work 1 🗆 `	vat ⟨? Yes 2∐N		. Describe how	injury occurred	
еппс	3 Suicide 6 Could not be 4 Homicide determined	Zoe. Flace of III	jury - At home, far tc. <i>(Specify)</i>	m, street, fa	ctory, office		28f.	Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
Medical Certification: 10			of examination and						use(s) and manner as te and place, and due	
Me	29b. Signature and title of certifier	///	m _		29c. License	number		296	d. Date signed (Monti	n, Day, Year)
	- Shevier 1	frul	e n	0	D	U0646	515		6/8/07	
	30. Name and address of person who	completed cause of o			7 1/1120	anct	~ 1/1 ÷	5g it	. Rockvi	20850

State Registrar 31. Date filed (Month, Day, Year) JUN 12 2007



			For State Registrar	State of Mar		ertificate of L			ienez 0 1 7	20818
79 75.	Physici	20	Decedent's Name (First, Middle, La	st)				2. Date of Deat Month		3. Time of Death
	/Medic	al	EDMUND 4a. Facility Name (If not institution, giv	SCOTT	REAMY	4b. City, Town, or	Location of Death	JUNE	10, 2007 4c. County of Death	12:50 P ^M
	Examin	er	2022 RAVENSWOO				TSVILLE			GEORGES
327	Funeral Director		214-/2-433/	TVM 2DE	In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, APRIL 26	Year) Cou	nplace (State or Foreign untry) YLAND
	land ow it		Usual Residence of Decedent 10a. State 10b. County	10	0c. City, Town or L	ocation.				10d. Inside City Limits
	a-f sh	ctor	MD. PRINCE	GEORGES	Н	YATTSVILLI	Ε			1 X Yes 2 □ No
	with the Marylandia or 28a-f show	Director	10e. Street and Number			10f. Zip Code		10	ng. Citizen of What Cou	untry?
	eath v ns 23a must	Funeral	2022 RAVENSWOO	D ST. 12. Was Decedent Eve	er in U.S. 13	. Was Decedent of His If Yes, specify Cuba	0782 spanic Origin? (Sp	ecify Yes or No-	U.S.A.	ican Indian,
336	be filed within 72 hours after death with the Maryland that Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 📉 No	n', Mexican', Puèrto Specify:	Rićan, etc.)	Black, White Specify: WH	e, etc.
2-0(72 hou natura dical E		15. Decedent's E (Specify only highest gra	ducation (de completed)	16a. Dec	edent's Usual Occupa e kind of work done o	ation Juring most of work	ing	16b. Kind of Business/I	
21215-0036	within sne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	e kind of work done of DO NOT use retired, MECHANI (9	AUTO	1
	I Hygie other ent, th	Be Co	17. Father's Name (First, Middle, Last)		TILCHANI	18. Mother's Name	e (First, Middle, N		,
Maryland	should be and Mental s marked o umatic eve	To B	WARREN	J. REAMY					GRATH	
lar)	C/ 10 5 62		19a. Informant's Name/Relationship						City or Town, State, Z	
	1 and Health tem 27	11	ZULMA E. AYENDEZ- 20a. Method of Disposition			CAVENSWOO cosition (Name of ematory or other place			LE, MD. 20 20c. Location - City or 1	
altimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont	Themoval mom State		ematory or other place CREMATORY	ŧ	2007	RIVERDALE,	MD.
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lice		,	22 Name and Addres	S of Eacility FUNERAL H	IOME & CH	REMATORIUM, RDALE, MD.	P.A.
8	* 2		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused th						Approximate Interval Between
3	Physician		Immediate Cause (Final disease or condition		NCER, ME	TASTATIC				Onset and Death
	/Medical® Examiner		resulting in death)	Due to (or as a c	onsequence of):					
- 1	92 FR	ler	Sequentially list conditions,	b. Due to or as a c	onse uence of:					
	cuted nd transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C						
68760,	icate be executed physician and s the burial-transit	edical Ex	resulting in death) Last	Due to (or as a c	onsequence of):					
_		Medi	IF FEMALE:							
O. Box	at the death certific by the attending p tached for use as t	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf 1 Live birth 2 l 4 Pregnant at tin 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
<u> </u>	s that the		Part II. Other significant conditions	contributing to death but r	not resulting in the	underlying cause give	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Suds	w requires that been signed to should be deta	ed by						1 □ Ye	es 2 No 3 Pro	obably 4 ∏Unknown
Vital Records,	The la te has	Completed						24a. Was ar autops perform 1∐ Yes 2	y prior to c ned? death?	topsy findings available completion of cause of
/Ita	ilcian: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	(I)		Tou.	26. Place of Deat			
ō	Physl r this c ral dire	٦.	1 ☐ Yes 2 ☒ No 27. Manner of Death	Hospital: 1 ☐ Inpatient	2 ER/Outpation		4 Li Nursing Ho		nce 6 Other (Spec	cify)
O	nding th. :: After e funer	tion	1 X Natural 5 Pending 2 Accident investigatio	(Month, Day Y		Work	? Yes 2 □ No	20d. Describe no	w injury occurred	
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined		- At home, farm, s (Specify)	street, factory, office		28f. Location (St. City or Town	reet and Number or Ru , State)	ral Route Number,
	e Hospita 124 hours e Funera letely fille	Medical C		nysician: To the best of r miner: On the basis of ex and manner state	xamination and/or					
	To the	Me	29b. Signature and title of certifier	1	Al.	MD 29c. License	number	29	9d. Date signed (Month	n, Day, Year)
	15		Hen.		/		54178		JUNE 11, 2	007
			30. Name and address of person who HARVINDER SING	completed cause of deal GH, M.D.			.W., WASH	INGTON,	D.C. 20010	
	Sta		31. Date filed (Month, Day, Year) JUN 12 20	On in incidend						
	Registr	ar	JON IN CO	William .	115 119	Contract of the second				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5, June 2007 2103 Rahmi Razieh /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Ye Oct. 26, 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year Months Days Hours Country) 1 □ M 2 😾 F Oct. Iran 82 224-21-1958 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2□No Director Bethesda Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20817 U. S. A. 7210 Swansong Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ဩ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Khanum Bashi Reza Mohammad Abbassi ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10901 Out Post Drive, N. Potomac, Maryland 20878 Behrouz Rahmi - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐Removal from State Parklawn Cemetery 6/10/2007 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 20852 Donald 23a. Part1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Days Immediate Cause (Final Acute Myocardial Infarction Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Years Coronary Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-tran Due to (or as a consequence of) attending physician for use as the buria by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12-months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐Unknown 9 Unknown AHM 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Urosepsis Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has t RAZIEH autopsy 1∐ Yes 2X No director, I 25. Was case referred to medical examiner?

1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury 28d. Describe how injury occurred 28h. Time of

To the Hospital or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760, Division or Vital : After this (death. 3

Medical Certification: To

the Funeral Director: npletely filled in by the Ó 24 hours

5 ☐ Pending investigation

6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

(Month, Day Year)

28c. Injury at Work?

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29c. License number 41507

29d. Date signed (Month, Day, Year) June 6, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Nancy Davenport 3301 New Mexico Avenue, N.W., Washington, D. C.

State Registrar 31. Date filed (Month, Day, Year) 12 JUN



2 O Please Type or Print in Black Indelible Ink Engure All Conice Are I

			1 - For State Registrar	State of M		d / Depa		t of H	ealth ar		ental Hygi	•	7	20820
			1. Decedent's Name (First, Middle, Las	t)						-	2. Date of Death			3. Time of Death
	Physici /Medio		Raymond		Ra	aub					June 1	6, 200	Year 7	10:45 P.
1	Examin		4a. Facility Name (If not institution, give Citizens Nurs				4b. City,		Location of ederic			4c. County of		erick
	Funeral		5. Social Security Number 6. S		ge (In yrs.	last birthday)	If Under		If Under 24		8. Date of Birth			
	Director			□M 2□F	88	Yrs.	Months	Days	Hours	Min.	Dec. 13	, 1918	Соц	place (State or Foreign Maryland
	within 72 hours after death with the Maryland one. than 'naturel', or items 23a or 28a-1 show he diese Engliner must be collified at	tor	Maryland 10b. County Fred	erick	10c. City	y, Town or Lo	cation	Free	derick	ζ.				10d, Inside City Limits 1 ☐ Yes ※ No
	with the	Direc	10e. Street and Number 8328-A Ball Roa	d	1		10f. Zip	Code	21704		10	g. Citizen of Wh		ntry?
	ns 23	era	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. V	Was Deced	lent of Hi			city Yes or No-			can Indian,
36	rs after of i, or its	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces' 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	? No	1	fYes, spec I□Yes 2		n, Mexican, 1 Specify:	Puerto I	cify Yes or No- Rican, etc.)		White,	
Ö	2 hou	ed	15. Decedent's Ed		1945	16a Decec	lent's Usua	Occupa	ition		10	6b. Kind of Busi		
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Marylar ital Hygiene. ed other than "naturel; or itsms 23a or 28a-1 show svent, the Medical Examinat must be notified at	Completed by Funeral Director	(Specify only highest gra	de completed) College (1-4or	5+)	(Give life. L Roof	kind of wor DO NOT us	rk done d se retired,	luring most o)	of workir	ng			
d 2	Hygid Hygid Sther ant,	ပိ	17. Father's Name (First, Middle, Last)			KOOI	er		18. Mother's	s Name	(First, Middle, Ma			Company
lan	should be nd Mental marked c matic sve	То Ве	Guy Raub								hittinge			
Mary	d 2 s th ar 7 is trau		19a. Infompent's Name/Relationship (1) Margaret Bowers/	,, ,					and Number	or Rura	Route Number.	City or Town, Si		
ore,	permit. Pages 1 en Department of Heel Importsnt: If Itsm 2 any Injury or other once.		20a. Method of Disposition 1 X Burial 2 Cremation 3		20b. P	lace of Dieno	eition /Nor	a of	cans	D	ate 20	Dc. Location - C	ity or To	own, State
altim	permit. Pa Departmen Importent: any Injury		4 □ Donation 5 □ Other (Specify 21. Sign your of Buneral Service Liceo	, ,	Çen	netery	. Name and	d Addres	s of Facility	une	22, 200 Funeral reet, Fr	7 Owing	s M	ills, MD
<u> </u>	89 2 2 8		Julian C	· Isaya	MOC	0021	06 Es	ancest (l bası Church	Sti	runerai reet Fr	Home ederick	MI	21701
	Physician /Medical		23a. Part 1. Enter the disease, or composition of the composition of t	a. Due-te-(or as	ine.	as ev	er the mode	e or dying	such as ca	ardiaco	r respiratory arres	otter for	,	Approximate Interval Between Onset and Death
	Examiner	- G	Sequentially list conditions,	b. Due to (or as										
	e be executed /sician and e burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last	cDue to (or as										
3760,	ate be ex hysician he burial	cal		d	a consequ	derice or).								
Box 68	n certifica anding ph use as t	n/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date	of delive	ery
P.O. B	that the death certificate be executed ed by the ettending physician and deteched for use as the burial-transit	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 4□Pregnant a 9□Unknown			Ectopic pre Other (spe					Monti	h	Day Year
ds, P	uires that signed b	d by Pł	Part II. Other significant conditions of	entributing to death t	out not resu	ulting in the ur	nderlying ca	luse give	n in Part I.		23e. Did toba	1/		he cause of death?
Vital Records,	Physician: The law requires that the death certifica this certificate has been signed by the ettending phyral director, page 2 should be deteched for use as the	Completed								_	24a. Was an autopsy performe	prio de:	ere auto or to co ath? Yes	opsy findings available impletion of cause of
/ita	cian: ertific	Be (25. Was case referred to medical examiner?			- V.	-		26. Place of	f Death	Check only one	V		V
ر ا	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page	၉	1 Yes 2 Nio 27. Manger of D at 1 D Natural 5 Pending	Hospital: 1 Inpati 28a. Date of Inju (Month, Da	ırv	ER/Outpatien 28b. Time of Injury		A Othe Bc. Injury Work	4 Nursi		ne 5 Residen			у)
Division of	Hospital or Attanding 24 hours after death. Funeral Director: After tely filled in by the fune	Certification;	Accident investigation 3 Suicide 6 Could not be	28e. Place of In	jury - At ho	ome, farm, stre	М	1 🗆 Y	es 2 □ No		8f. Location (Stre	et and Number	or Rura	al Route Number,
ā	ospital or A hours after uneral Directly filled in by		4 Homicide	building, e						00211	City or Town,			(W. d)
	To the Hos within 24 ho To the Fun completely	Medicai	(Check only I Medical Exam	iner: On the basis of and manner st	if examinat	tion and/or inv	estigation,	in my op	inion, death	occurre	nd at the time, date	e and place, an	d due to	the cause(s)
	To To Con	2	29b. Signature and title of certifier	afau	n		29 c.	License \mathcal{D}^-		77	/ 290	d. Date signed (Month,	Day, Year)
			30. Nam and address of person and Robert L. Kau	omy leted cause of o				ıth s	Street	Fr	ederick	MD 21	701	
1	Sta Registr		31. Date filed (Month, Day, Year)	32. Registi	ar's Signal	ture	,					, .w 21.	. 01	
DH	MH 17 Rev 1/20	001	- JUN 2 7 2	107 Julie	Se de	OF G	NAI							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 6:25 P. M Sidney Schofer June 6, 2007 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Bethesda

| Funder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, pay, Year) | Aug. | 12, 1909 Montgomery Suburban Hospital 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) Months 1 XM 2 ☐ F Vrs 579-09-3441 97 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Silver Spring 1 X Yes 2 No Montgomery Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15310 Beaverbrook Ct. Apt. 2F United States 20906 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □XYes 2 □ No
If Yes, Give WW II
Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🔼 No White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U.S. Government Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sohea Jacob Schofer Lena 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11215 Seven Locks Rd. Potomac, MD 20854 Stanley Schofer/Nephew 20b. Place of Disposition (Name of cemeter), exematory or other place)
Geo. Wash. University
Medical Center 200 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 2007 Signature of Fune al Service Licensee 22. Name and Address of Facility Columbia Mortuary Services, Inc. 9013 Annapolis Rd. Lanham, MD 20706 an 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Failure disease or condition resulting in death) Due to (or as a consequence of): Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🖾 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy perform 2 No 26. Place of Death (Check only one) Hospital: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner Division or Vital Records, P.O. Box 68760 requires that the death certificate be Sidne within 24 hours after death.

To the Funeral Director: After this completely filled in the funeral Director. certificate

Physician

/Medical

Examiner

Funeral

Director

28a-f show

should be filed within 72 hours after and Mental Hygiene.
s marked other than "natural", or itel umatic event, the Medical Examiner

th and Mental H 7 is marked oth traumatic even

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once.

Baltimore, Maryland 21215-0036

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sa or 28a-f shit to be notified a

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Physician/Medical

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Certification:

Medical

Chronic Obstructive Pulmonary Disease Dementia: Advanced, Malnutrition Pleural Effusion 25. Was case referred to medical examiner? 27. Manner of Death 1 Natural 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifiei 🛮 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

29b. Signature and title of certifier

29c. License number D53367

29d. Date signed (Month, Day, Year) June 7, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shyamsundar Rajan, M.D.

9801 Georgia Avenue Suite 117 Silver Spring,MD 20902

State Registrar

31. Date filed (Month, Day, Year) JUN 12 2007



			For State of Maryland State of Maryland	•	tificate of L		lental Hygle Reg.	0 0 0 0 0	20022
	Physici	an	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
4	/Media	al	MAXWELL R. SCHNELLER				06/10/200	7	1:30 A M
	Examir	er	4a. Facility Name (If not institution, give street and number) SUNRISE ASSISTED LIVING		4b. City, Town, or	BETHESDA		4c. County of Deat	
-	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	t birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	MONTGO 9. Birtl	hplace (State or Foreign untry)
	Director		089-03-0838	Yrs.	Months Days	Hours Min.	(Month, Day, Ye 10/27/190		GARY
	land ow It		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	Town or Loc	ation				10d. Inside City Limits
	a-f sh ified	ctor	MARYLAND MONTGOMERY		NORTE	H BETHESD	Α		1x Yes 2 No
	or 28 or 28 oe not	Director	10e. Street and Number		10f. Zip Code		10g.	. Citizen of What Co	untry?
	s 23a		5550 TUCKERMAN LANE #314			20852		U.S.	
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes, 2 ☒ No If Yes, Give Year or Dates:		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No		ecity Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: W	
21215-0036	72 ho "natur dical	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupa	luring most of work	16l	b. Kind of Business/I	industry
121	within ene. than '	Jumo	Elementary/Secondary (0-12) College (1-4or 5+)	life. D	O NOT use retired, MERCHAN)		ፑ፤ ፑር ጥ ኮ ር	NIC RETAIL
19	e filed val al Hygie other i	Be Co	17. Father's Name (First, Middle, Last)		TIEROIIA		e (First, Middle, Mai		NIC KEIAIL
ylar	should be and Mental s marked o	To E	SANDOR SCHNELLER			SARAH RO	SENBAUM		
Maryland	12 short and risk mark							ity or Town, State, Z	
	1 and Health tem 27 other tr		MARLENE HARTE/DAUGHTER 20a. Method of Disposition 20b. Place	e of Dispos	sition (Name of	1 1		BETHESDA,	
Baltimore,	t. Page rtment c rtant: If rjury or	100	4 □ Donation 5 □ Other (Specify) MOUN	T SHA	RON CEMET	TERY 06/1		PRINGFIEL	
Ba	permi Depa Impo any ir	0.00	21. Signature of control Signature of the Cont	ED	91 ROCKVI	EL FUNERA ELLE PIKE		LE, MARYL	AND 20852
4			23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not ente	r the mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death) a. CONGESTIVE HI Due to (or as a consequen		FAILURE				
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¥°	pe sit	iner	if any, leading to immediate cause. Enter Underlying	nce of):					
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68760,	tificate be executed g physician and as the burial-transit	edical	CHRONIC OBST	RUCTI	VE PULMON	NARY DISE	ASE		
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. Box	death cert e attending d for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deatt	eath 3 □l	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
P.0	that the dened by the a	hys	9 ☐ Unknown						
	w requires that the death cer been signed by the attendin should be detached for use	þ	Part II. Other significant conditions contributing to death but not resultin	ig in the und	derlying cause give	n in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to 2☑xNo 3☐ Pro	the cause of death? bably 4 □Unknown
Vital Records,	law as b 2 sl	Completed			-		24a. Was an autopsy performed	prior to c death?	topsy findings available completion of cause of
ita I		Be C	25. Was case referred to medical examiner?			26. Place of Death	1 Yes 2 K Check onlone)	No 1∐Yes	2 No
	Physic this ce al dire	P	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/	/Outpatient		4 LI Nursing Ho		e 6 Dother (Spec	ASSISTED
Division or	ding I	ertification:	1 X Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	3b. Time of Injury	28c. Injury Work M 1 □ Y	rat ? ∕es 2 □ No	28d. Describe how i	injury occurred	
<u>:</u>	al or Attences after death	Certific	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined At home building, etc. (Specify)	, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	To the Hospital or / within 24 hours after To the Funeral Dire Completely filled in b	Medical (29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	occurred at the tim estigation, in my op	ne, date and place, pinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 to the comple	M	29b. Signature and title of conflien		29c. License D5369			Date signed (Month	
,	105		30. Name and address of person who completed cause of death (Item 23 DR. AJAY REDDY, 6320 DEMOCRACY BLV	(Type, P	erint) ETHESDA,	MARYLAND	20817		
ľ	Sta Registr		31. Date filed (Month, Day, Vear) 32. Registrar's Signature	y A	action	-			

State Registrar 31. Date filed (Month, Day, Year)

JUN

13

200

Division or Vital Records. P.O. Box 68760

32. Rejistrar's Signature

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	State Of Ivial	-	rtificate of		, ,	ene g. No. 2 1 1 1	20324
100	Physici	an	1. Decedent's Name (First, Middle, Last)					Date of Death Month	Day Year	3. Time of Death
	/Medi		Robert Norman	Schwart	z			June 12,	2007	5:10 am
	Examir	er	4a. Facility Name (If not Institution, give s	-/			r Location of Death		4c. County of Dea	
			10101 Governor Wa 5. Social Security Number 6. Sex		vy., #321 In yrs. last birthday)	Colu If Under 1 Year	mbia If Under 24 Hrs.	9 Date of Birth	Howa	
ü	Funeral Director		-	M 2□F 84	Yrs. last birthday)	Months Days	Hours Min.	8. Date of Birth (Month, Day, Sept. 11	rear)	thplace (State or Foreign ountry) assachusetts
	yland now at		10a. State 10b. County	1	0c. City, Town or Lo	ocation				10d. Inside City Limits
	Marylan f show ied at	호	Maryland Howard		Columbia					1 X Yes 2 ☐ No
	r 28a	irec	10e. Street and Number		COTUMBLE	10f. Zip Code		10	g. Citizen of What C	ountry?
	h with	Funeral Director	10101 Governor War	field Pkwy	7., #321		21044		USA	
	ems dear	ner	11. Marital Status	Was Decedent Ever Armed Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Amo	
9	or it		1 ☐ Never Married 2 X X Married	1 May Yes 2 □ No If Yes, Give		1 □ Yes 2 ☑ No	Specify:	r nouri, cto.)	Black, Whi	
8	hours ural"	d by	3 Widowed 4 Divorced	Year or Dates:	1943-46				Specify: Whi	te
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of work d)	ring	6b. Kind of Business	
12	withii iene. than the M	щo	Elementary/Secondary (0-12)	College (1-4or 5+) 5 +		Physici		40	vernment nd Analys	
b	illed I Hyg other	Be C	17. Father's Name (First, Middle, Last)					e (First, Middle, M		15
lan	should be filed wand Mental Hygies marked other tumatic event, th	To B	Abraham Theodore	Schwartz			Marie Ag	nes Stud	ds	
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other traumatic	Γ.	19a. Informant's Name/Relationship (Typ	e. Print)	19b. Mailir	ng Address (Street	and Number or Rui	al Route Number,	City or Town, State,	Zip Code) 21044
	1 and 2 Health em 27 i		Mary Catherine Sch	wartz/Wife	ı					Columbia, MI
ore	ges 1 a It of Hea If item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re	amoval from State	20b. Place of Dispo	osition (Name of matory or other plac	ce)	Date 2	0c. Location - City or	
Ë	Pa T:e⊓ Z		4 □ Donation 5 □ Other (Specify)	Sinovar nom State	Metropol	itan Crem	atory Jun		levandria	. Virginia
Baltimore,	permit, Pag Department Important; any Injury once.		21. Signature of Funeral Service License	20.			ss of Facility Collins	Funeral	Home Inc.	· District American
			23a. Part1. Enter the disease, or complic	cations that caused th	e death. Do not ent	er the mode of dyin	SITY BIVO Ig, such as cardiac	or respiratory arres	lver Spri	Approximate
	Physician	50 Y	shock, or heart failure. List only on Immediate Cause (Final							Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a c	ve Heart onsequence of):	Failure				More than 10
	Examiner		Sequentially list conditions, b.	Chronic	Ostructi	uo Pulma	sary Diec	260		Years
	p #	iner	day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a s	Obstricti	VC Turmen	inty babo	are		More than 10 Years
	ecute and -trans	Examin	that initiated events resulting in death) Last	Due to (or as a c	anacauanae eft					
68760,	rificate be executed ng physician and as the burial-transit			Due to (or as a c	onsequence or).					
587	tificate ig phys as the	Jedical	d.							
Вох	eath certi attending for use a	N/M	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome pf					23d. Date of de	livery
m	death e atte d for	Physician/	in the past 12 months? 1 □ Yes 2 □ No	1 ☐Live birth 2 [4 ☐ Pregnant at tin		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	at the de by the a tached	hys	9 ☐ Unknown	9□Unknown						
	as tha	by P	Part II. Other significant conditions conf	ributing to death but r	not resulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
ord	w require been sig should b							1 ☐ Yes	3 2 3x No 3 □ P	robably 4 □Unknown
e C	e law i has be je 2 sh	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
<u>=</u>		9						perform 1□ Yes 2	ed? death?	2 □ No
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	anital:		l out-		h Check onl one)	
or Vital Records,	dir ys	2	1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatien		4 LI Nursing Ho		ice 6 Other (Spe	cify)
O	ding After funer	ioi	1 ☑ Natural 5 ☐ Pending	(Month, Day Y	ear) Injury	Work	yat ⟨? Yes 2∐No	28d. Describe hov	v injury occurred	
Division	I or Attending after death. Director: After I in by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of injury	- At home, farm, str			28f. Location (Stre	eet and Number or Ri	ural Route Number
<u>S</u>	after after Dire d in b	ertii	4 ☐ Homicide determined	building, etc. (Specify)			City or Town,	State)	area riodio rearroot,
	To the Hospital or Atten within 24 hours after deatl To the Funeral Director: completely filled in by the		(Check only 2 Medical Examin	ician: To the best of n er: On the basis of ex	ny knowledge, death amination and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the car	use(s) and manner as	s stated.
	To the le within 24	Medical	29b. Signature and title of certifier	and manner stated	1.	29c. License				
	F ¥ F 8		255. Signature and title of certifier	A 1			D 202564		d. Date signed (Mont	
9	841	-	20 Name and address of the	me Me		1 2	ן שיכניים ע	3	6/12/20	07
			30. Name and address of person who cor Andrea Karp, M.D.				, 2nd Flo	or, Kens	ington, M	D 20895
	Sta	-	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	m. M. A.				

DHMH 17 Rev 1/2001

Funera Director

		For State Registrar		State o	f Maryland		artment <i>rtificate</i>			nd M	ental Hy	ygiene Reg. No.		7 0	2001
» Physici		1. Decedent's Name (Stith, J	r.						2. Date of D Month June		200		of Death
/Medic Examir		4a. Facility Name (If n		_	mber)		4b. City, T		Location o				County of Dea		
uneral		5. Social Security Nur 163–05–243		. Sex 1⊠M 2□F	7. Age (In yrs. la 95	st birthday) Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of B (Month, D	av Vearl	912 9. Bi	rthplace (Sta country) irgini	te or Foreign a
a-f show	Director	Usual Residence of D 10a. State MD	10b. County	arundel		Town or Lo	ocation a Park			·					e City Limits
23a or 28 ust be no	ral Dire	10e. Street and Numb					10f. Zip (21146	5		10g. Citi	zen of What C		
Department of Health and Mentain Inglene. Important: If lear 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 3 ☐ Widowed 4		Armed Fo	2 ⊠ No ∕e		Was Decede If Yes, speci 1 ☐ Yes 2	fy Cubar	spanic Orig n, Mexican Specify:	jin? (Spe , Puerto l	cify Yes or N Rican, etc.)	0-	14. Race - Am Black, Wh Specify: Wh		l,
than "natul Medical	Completed			Education grade completed) College (1	I-4or 5+)	(Give life.	dent's Usual kind of work DO NOT use NEMICA	k done du retired)	uring most			1	nd of Business DuPont	s/Industry	
ental raygie ked other l ic event, th	To Be Co	17. Father's Name (Fi		est)	,		101112 001		18. Mothe	r's Name	- (First, Middl Cowns				
19a. Informant's Name/Relationship (Type. Print) Hannah W. Stith/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Hannah W. Stith/Wife 20b. Place of Disposition (Name of Date 20c. Local Route Number) 20c. Local Route Number or Rural Route Number, City or Hannah W. Stith/Wife 20c. Local Route Number or Rural Route Number, City or Hannah W. Stith/Wife 20c. Local Route Number or Rural Route Number, City or Hannah W. Stith/Wife 20c. Local Route Number or Rural Route Number, City or Hannah W. Stith/Wife 20c. Local Route Number or Rural Route Number, City or Hannah W. Stith/Wife 20c. Local Route Number or Rural Route Number or Rural Route Number, City or Hannah W. Stith/Wife 20c. Local Route Number or Rural Route Number, City or Hannah W. Stith/Wife 20c. Local Route Number or Rural Route Number, City or Hannah W. Stith/Wife 20c. Local Route Number or Rural Route Number or Rural Route Number, City or Hannah W. Stith/Wife 20c. Local Route Number or Rural Route Number, City or Hannah W. Stith/Wife 20c. Local Route Number or Rural Route Number or Rural Route Number, City or Hannah W. Stith/Wife 20c. Local Route Number or Rural Route Number										City or Town, State, Zip Code) Park, MD 21146					
ment of he lant: If Item jury or oth		4 ☐ Donation 5	Cremation 3 ☐ Other (Spe	* -	State C6	tro Ci	matory or other cemato	ry ry		June 2007		F .	cation - City o		
Impor any in once.		21. Signature of Fundamental Signature of Signature of Fundamental Signature of	my 9	All		4	Rame and Barran 195 Go	v. R	itch:	re Hv	vy. S	evern	a Park a Park	Funer MD 2	
bhysician and ledical aminer sthe burial-transit	dical Examiner	snock, or neart Immediate Cause (F) disease or condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events resulting in death) La	inal litions, rediate ving	b	(or as a consequ	ence of):	VASC	LAI	2	Acc	BEN	<i>*</i>		Onset a	Between nd Death
winin 24 nous after beam. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	1 ☐ Live b	tcome pf pregnar birth 2 Fetal nant at time of de own	death 3	⊒Ectopic pre ⊒ Other (spe					1	23d. Date of de Month	elivery Day	Year
n signed b ıld be deta	b	Part II. Other signific			eath but not resu	_	nderlying ca	use give	n in Part I.				se contribute	to the cause Probably 4	
24a. Was an autopsy performed? 1 Yes 2 12 No 1								24b. Were a prior to death?	completion	ngs available of cause of					
certif	Be C	25. Was case referre examiner?		Hospital:	Inpatient 2 1		nt 3 □ DO/	Otho	p-		(Check only		6 □Other (Sp	if -1	
an. r: After this e funeral d	ation: To	27. Manner of Death 1 Natural 2 Accident	5 ☐ Pending investigat	28a. Date (Mon	·	28b. Time o		Bc. Injury Work		2	28d. Describe			өспу)	
s arrer der al Directo ed in by th	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)								2	28f. Location City or To	(Street an own, State	d Number or F)	Rural Route N	Number,
the Funer	edical														
70 T	M	29b. Signature and ti	tle of certifier	17te	7			D3		87			te signed (Mor		
1/10		30. Name and address	n KA	72, MY	31	ROBI	wson	1 6	2UA-D	5	every	na R	irk, n	nD Z	146
Sta Regist	31. Date filed (Month Park Year) 2007 Registrar's Signature														

Guerara T 07-04010		Please Type or Print in Black Indelible Ink. Ensure Al	All Copies	Are Legil	ble.	
UNK UNK	1-	State of Maryland / Department of Health and M For State Certificate of Death	/lental Hyg	jiene Reg.	No. 201	17 2082
Physician	_	eqistrar . Decedent's Name (First, Middle,Last)		Date of Death		3. Time of Death 2008 hrs
Medical Examine	er	Geroning C-uzvara Tovar		Month D May 26, 200	7 4c. County of Death	2008 HFS
4		la. Facility Name (if not institution, give street and number) 203 North Fruitland Boulevard 4b. City, Town, or Local Salisbury			Wicomico	
Funeral	;	3. Social Security Number 6: Sox	f Under 24Hrs. Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Birt Foreig	n
Director		54-09-0997 1XM 2 F 33 Yrs.		01-08	-1974 Co	intry) Mexico
япу	<u> </u>	Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
and Fshow	<u>.</u> [md Wicomico Salisbury		140-	. Citizen of What Cour	1 Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner muss be notified at once.	Director	10f. Zij/ Code	804	Tog.	mexic	
with the is 23a (12. Was Decedent Ever in U.S. 13. Was Decedent of Hispania If Yes, specify Cuban, Me.				can Indian, Black,
death or iten	Funeral	Never Married 2 Married 1 Yes 2 No		etc.)		21.00
rs after ural", miner	ᅪ	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation ((Give kind of wor		Specify: //6b. Kind of Business/	ndustry
72 hou	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	O NOT use retired	d)	1	0
003(within giene. her tha	Completed	77. Father's Name (First, Middle, Last)	Mother's Name (F	First, Middle, Ma	iden Surname)	r Co.
21215-0036 Jud be filed within 7 I Mental Hygiene. I marked other than it marked than than	Be C	Jose' Guevara M	laria	Cleo	tilde 7	ovar
21) thould the mid Mer is mar	₽	19a. Informant's Name/Relationship (Type, Print)				e, Zip Code)
my MI and 2 s lealth a tem 27	}	The Toyar Herrera 286 Ocean accordance (Name of definition (Name o			20c. Location - City or	Town, State
more Pages 1 nent of H ant: If i	1	1 XBurial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Comunicated de Palem	06/2	3/07	SLP	
Baltimore, MD permit. Pages I and 2 she Department of Health and Important: If item 27 is injury or other traumant	ł	21. Signature of Funeral Service Licensee 22. Name and Address of F	Facility 3 4	nhie Sn		eral Home
Physician	-	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such	ch as cardiac or r	respiratory arres		Approximate Interval
** /We dical	-	failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries	4			Between Onset and Death
aminer		or condition resulting in death) Due to (or as a consequence of):				
	Je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
N	tamine	cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):		-		
executed an and al - transi	a E	d				
50, te be ex ysician	ledic	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delive	<u> </u>
Box 68760, e death certificate but the attending physical for use as the but	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnan	су	Month	Day Year
Sox death c	ysic	1 Yes 2 No 9 Unknown g Unknown				(t)
, P.O. Box 68760, res that the death certificate be executed signed by the attending physician and be detacted for use as the burial - transit	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.		acco use contribute to	the cause of death?
IS, P quires t en sign	ted t			24a. Was a	n 24b. Were a	utopsy findings available
of Vital Records, ng Physician: The law require Ner this certificate has been si meral director, page 2 should be	Completed			autops perform 1 V Yes 2	ned? death?	completion of cause of
tal Rec tian: The l certificate l		23. Was case referred to intedical	f Death (Check o			
Vital hysician: this certif	To Be	1 V Yes 2 No			Residence 6 V Oth	er: Scene
n of V ding Phy h.: After the		27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury and Injury 1 Natural 5 Pending May 26, 2007 2006 hrs 1 Yes			nvolved in auto c	ollision
Division Hospital or Attendiv 4 hours after death. Funeral Director: A	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office build	lding, etc.	28f. Location (Si or Town, St		Rural Route Number, City
Divi	Certi	4 Homicide determined (Specify) Local Street	- La	203 North Fruit	tland Boulevard, Sa	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buring.	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, do	e and place, and death occurred at	due to the cause t the time, date a	e(s) and manner as stand place, and due to	the cause(s)
To To Your To Com	Med	and manner stated. 29b. Signature and title of certifier 29c. License n			29d. Date signed (N	
		O.C.M.	l.E. 		May 27, 2007	
2		30. Name and address / person who completed cause of death (Item 23a) Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltim	more, MD 21	201		
St	ate	31. Date filed (Month, Day, Year) 31. Registrar's Signature			·	
Regist	rar	JUN 1 3 2007 Blown D. Agree				

			For State Registrar		State of Ma	aryiand / i		rtment of F tificate of		and Me	ntai Hy	/gien Reg. N	2007	20827
Ė	Physici	20	1. Decedent's Nam	e (First, Middle, La	ist)					2.	Date of D Month	eath Da	ay Year	3. Time of Death
1	Physici /Medic		Paul :	Frank To	oth					J.			2007	3:45 p M
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, o	r Location o	of Death		40	c. County of Deat	h
					ial Hospi			Prince					Calv	
	Funeral Director		5. Social Security N 150-26- Usual Residence o	3866	5ex 7. Ag 1. XM 2□ F	e (In yrs. last bi 95	Yrs.	Months Days	Hours	Min.	Date of B (Month, D / 31 /	ay, Year	Co	nplace (State or Foreign untry) ngary
	land ow		10a. State	10b. County		10c. City, Tow	n or Loc	cation						10d. Inside City Limits
	Mary I-f sh fied a	ţ	MD	Calv	vert			Prince	Fred	deric	k			1 X Yes 2 □ No
	r 28a	Director	10e. Street and Nu	_				10f. Zip Code			-	10g. C	itizen of What Co	untry?
	th will	a	437 Rac	chels Wa	У			2	0678				USA	
	r dea	Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Vas Decedent of I Yes, specity Cub	lispanic Ori an, Mexicar	igin? (Specif	y Yes or N	0-	14. Race - Amer Black, White	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ρ	1 ☐ Never Mari 3 ☐ Widowed	ried 2 X Married 4 □ Divorced	1 Yes 2 I If Yes, Give Year or Dates:	No		□Yes 2XINo	Specify:		,		Specify: Wh	
5-0	72 hc 'natu dical	etec	(Spe	15. Decedent's E	ducation ade completed)	16a	(Give I	ent's Usual Occup kind of work done	durina mos	t of working		16b. I	Kind of Business/I	ndustry
2	vithin ne. han " e Me	Completed	Elementary/Seco		College (1-4or 5			O NOT use retire	•	J		G = 1	1 a p.c.;	
22	e filed wit al Hygien i other th vent, the		17, Father's Name	(First Middle Last	<u> </u>		GOT	d Maste		er's Name <i>(F</i>	iret Middle		Ld Refi	nery
Maryland	d be fairtal }	Be C	Istvan		,					ina 2			ii ournaine)	
Z	2 should be and Mental Is marked o	٩		ame/Relationship ((Type, Print)	198	o. Mailine	a Address (Street					or Town, State, Z	in Code)
Σ	nd 2 state at trau			eth Toth										D 20678
ē,	s 1 and 3 if Health item 27 other tr		20a. Method of Dis	position				sition (Name of natory or other pla		Date			ocation - City or	
E 0	r iii				Removal from State fy)	I -		ake Cre		6/7/2	007	Ве	ltsvil1	Le, MD
Baltimore,	permit. Pages 1 a Department of He: Important: If item any Injury or othe		21. Signature of F	uneral Service Lice	nsee Q		22.	Name and Addre					od F.H.	
_	20 E 20		6.	Wood	50			OB 430,					754	
Н			shock, or hea	art failure. List only	nplications that caused one cause on each li	the death. Do	not ente	er the mode of dyli	ng, such as	cardiac or re	espiratory	arrest,		Approximate Interval Between Onset and Death
4	Physician /Medical		Immediate Cause disease or condition resulting in death)		a. Ver	itricu	100	L tau	240	Soll	<u>i</u>			
	Examiner		,	•	Due to (or as	a consequence	,	ische	- > - '	L.				
и		e	Sequentially list co if any, leading to ir cause. Enter Under	onditions, nmediate	b. Due to (or as	a consequence		1 SCITE	MICA					
	outed id ansit	Examiner	Cause (Disease or that initiated events resulting in death)	iniury	. A	DOM	170							
ó	an an arial-tr		resulting in death)	Last		a consequence								
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			IF FEMALE:		00 1/									
Вох	death cerl e attendin d for use a	ian/	23b. Was deceder in the past 12		23c. If yes, outcome 1☐Live birth	2 Fetal deat		Ectopic pregnanc	y			T I	23d. Date of deli Month	very Day Year
P.O.	equires that the death certifen signed by the attending ould be Jetached for use as	Physician/M	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant at 9□Unknown	time of death	5	Other (specify) _						
	that ted by deta		Part II. Other signi	ficant conditions	contributing to death b	ut not resulting i	n the un	derlying cause giv	en in Part I.		23e. Did	tobacco	use contribute to	the cause of death?
rds	equires en sign ould be	d by	Dla	lene	Bared	RIGHT	5	Della	ma	D.	1 🗆	Yes 2	2 No 3 □ Pro	obably 4 □Unknown
S	> 0 70	Completed	,			2	,			Ì	24a. Wa		24b. Were au	topsy findings available
æ	0 T 0	mo									auto peri 1□ Yes	opsy formed?	death?	ompletion of cause of 2 □ No
ita	sician: Th certificate rector, pag	Be C	25. Was case reference	rred to medical					26. Place	e of Death (C				
Ž	Physician: this certific ral director,	ToE	1 Yes 3□	Mo	Hospital:	ent 2 ER/O	utpatient		4 ∐ Nu	ursing Home	5 ☐ Res	idence	6 □Other (Spec	cify)
no	ing P		27. Manner of Dear	th 5 ☐ Pending	28a. Date of Inju (Month, Da		Time of Injury	28c. Inju Wo:			I. Describe	how inju	ury occurred	
sio	Attending r death. ector: Atter by the fune	cati	2 ☐ Accident 3 ☐ Suicide	investigatio 6 ☐ Could not b		un. At home for			Yes 2 □ I			(04		180
Division or Vital Records,	lor At after o Direc	Certification:	4 ☐ Homicide	determined			arm, sire	eet, factory, office		281.	City or To			ral Route Number,
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certific completely filled in by the funeral director.	Medical Co	29a. Certifier (Check only one)		hysician: To the best miner: On the basis o	f examination a								
	Fo the vithin 2 Fo the comple	Mec	29b. Signature and	title of certifier	and manner sta			29c. Licens	e number			29d. D	ate signed (Month	n, Day, Year)
	⊢ s ⊢ ŏ		No	WASSE	00 00	M	D	200	364	9/21		0	Mon	
	7		30. Name and add		completed cause of d	eath (Item 23a)	(Type, F		204	101			15/04	
			DE MAJE					110 HOS	UHai	Ra.	3411	e 3	10 , ocin	ce fa donck
	Sta	ite	31. Date filed (Mor	nth, Day, Year)	32. Registr	ar's Signature			1				1111	020678
	Registr	ar	JUN	7 2007	Been 1	. Apar	W							

Time of Death

05:13 A

Birthplace (State or Foreign Country)

Wash., D.C

10d. Inside City Limits

1 ☐ Yes 2 No

Prince George's

U.S.A.

Black

Law Enforcement

Clinton, MD

Month

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Approximate Interval Between Onset and Death

Black, White, etc.

Physician /Medical Examiner

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Earl Eugene Tolson, Jr. Jun 3, 2007 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death 12208 Kinloch Court Upper Marlboro If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 X M 2 □ F Director 577-44-7349 72 Jan 26, 1935 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director MD Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12208 Kinloch Court 20772 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 NYes 2 No 1955 -1 ☐ Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced 1958 Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) U.S. Marshall 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Green Earl Eugene Tolson, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Velma Tolson /Wife 12208 Kinloch Court Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/09/07 Resurrection Cemetery 21, Signature of Funeral Service Licensee 22. Name and Address of Facility Glodep Sewell Funeral Home Servel 1451 Dares Beach Road Prince Frederick, MD 20678 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) M > 0 0, - 2, 1 155 in Due to (or as a consequence of) i a betin Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for sells consequence of Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) physician Physician/Medical as the attending p 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ ge. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an has director, page 2 s autopsy performed? res 25 No certificate 1 🗆 Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 K,ER/Outpatient 3 □ DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 06/13/17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2007

32. Registra Signature

ERIC MCDONALD MD

JUN

31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

7503 Surratts RD. Clinton, mD 20735

Physician /Medical Examiner

Physician

/Medical

Examiner

To Be Completed by Funeral Director

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" ~ " any injury or other traumatic event."

After this certificate has been signed by the atten funeral director, page 2 should be detached for u within 24 hours after death.

To the Funerel Director: A completely filled in by the fu

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Immediate Cause (Final disease or condition resulting in death)	. Fafal	arrhythm	ia	l		Onset and Death
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Part II. Other significant conditions co	entributing to death but not res	sulting in the underlying	g cause given in Part I.			o the cause of death?
				24a. Was an autopsy performed:	prior to death?	utopsy findings available completion of cause of
25. Was case referred to medical examiner?	- 22		26. Place of De	eath (Check only one)		
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27. Manner of Death 1★■Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, Sta	and Number or Ri ite)	ural Route Number,
29a. Certifier Check only 2 Medical Exam	vsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause curred at the time, date a	(s) and manner as nd place, and due	s stated. to the cause(s)
29b. Signature and title of certifier	, NO	2	9c. License number		Date signed (Mont	_

DHMH 17 Rev 1/2001

State Registrar

MICHALL

31. Date filed (Month, Day, Year)

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610 DUTCHMANS

LANE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROWLLY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1. 16b M GEORGE WATERS 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY Hebrew Home of Greater Wash Rockville If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days 1 🔀 M 2 🗆 F Wash.DC Director 579-48-2802 76 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits 28a-f show Examiner must be notified at Yes 2 □ No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 209_±0 U.S.A. 8814 Lanier Dr. #201 Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ♣ ♣ ♠ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married 2 1 ☐ Yes 2 🔀 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Stone Quarry Laborer 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown George Waters ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20910 19a. Informant's Name/Relationship (Type. Print) 8814 Lanier Dr, #201, Silver Spring, Harold Lee Waters (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State Nat'l Mem Pk 6/14/07 Laurel, MD 4 Donation 5 Other (Specify) 21. Signature 1 Funeral Service Linens 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N.Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cardio-Rec disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **1**No Sacra To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home P 1 ☐ Yes 2 No 3□ DOA 2 ☐ ER/Outpatient 5 ☐ Residence 6 ☐ Other (Specify) 27. Manur of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 ☐ Accident within 24 hours after death.

To the Funeral Director: completely filled in by the f 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20055362 ŧ 31. Date filed (Month, Day, Year) 327 Registrar's Signature State 2 2007 Registrar

Edward Williams, Jo	1	State For State egistrar	ate of N	/laryland		artment of rtificate of	Health and Death	d Menta	al Hygiene	Reg. No.	201	7 2003
Physician/ Medical Examiner	1	. Decedent's Name (First, Middl Edward		is Wil	lliam	s, Jr.			2. Date of D Month June 18	Day	Year	3. Time of Death 0929 hrs
)	4	a. Facility Name (if not institution Southern Maryland Ho		et and number)		b. City, Town, or I Clinton	Location of	Death		ounty of Death	
Funeral Director		5. Social Security Number 579–94–3986	6. Sex		ge (In yrs. I	ast birthday)	If Under 1 Year Months Days		24Hrs. 8. Date of Apri	Birth(MM/DE	Foreig	thplace (State or gn Washington puntry) D.C.
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the Maryland or 28a-f sh		Oe. Street and Number					10f. Zip Code 207 8	0 /.			n of What Cou ted Sta	
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Balti permit. Departn Import	1	21. Singular of Fundamental Service	R	Hole	-	60	0 Kenned	y Str		Washi	ngton,I	c. O.C. 20011
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complication	ons that cause	d the death	n. Do not enter t	ne mode of dying,	such as car	diac or respiratory	arrest, shoci	k, or heart	Approximate Interval Between Onset and
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Division o spiral or Attending hours after death. meral Director: After the force of the force		dete	ld not be rmined		partme		et, factory, office b	Juliumy, etc				trict Heights,
Division of Vital Records, P.O. Box 6876: To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Purearal Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the temperature of the funeral director. To Be Completed by Physician/Maddical Certification: To Be Completed by Physician/Maddical Certification:		29a. Certifier 1 Certifying P	miner:On t	To the best of r	ny knowlet amination	dge, death occu	rred at the time, dation, in my opinion	ate and place, death occ	ce, and due to the urred at the time, o	cause(s) and	manner as sta	ited.
To To con	<u> </u>	29b. Signature and title of certifi		manner stated	<u>i.</u>		29c. Licens	e number		29d. D	ate signed (M	onth, Day, Year)
		20102	Jes	2) Ne	0	222	O.C.	M.E.		June	19, 2007	
		 Name and address of persor Tasha Greenberg MD 		feted cause of stant Medio			Penn Street,	Baltimor	e, MD 21201			
State		31. JUN 2 2 2 2007 ear)	As:	32. Registr	ar's Sign	were de						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Madeline Theresa Willis June 5 2007 4:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County Calvert Memorial Hospital Prince Frederick Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🛛 F Yrs Director 577-38-5117 Jan. 10, 1930 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show an "natural", or Items 23a or 28a-f shov Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MDCalvert County Chesapeake Beach 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 3103 Dalrymple Road 20732 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Mudical Examiner 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White þ 3 ☐ Widowed 4 ₹ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bartender American Legion Hall 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Hilda Madeline Godfrey Fayette Clark 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3103 Dalrymple Road, Chesapeake Beach, MD 20732 Linda G. Grantham 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Sta-June 8. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 4 Donation 5 Other (Specify) Lakemont Mem. Gardens Davidsonville, Maryland 21. Signature of Fue 15 ce 16 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Michael W. 150 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Cardiovascular disease Atheroscienotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobageo use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 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Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Surana. D 50653 6-5-2007

Registrar
DHMH 17 Rev 1/2001

State

Road MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SYAN C. SURANA

Chur us ton

32. Registrar's Signature

Deale

7 2007

31. Date filed (Month, Day, Year)

JUN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** CHARLES L. WASHINGTON 5, 3:30 PM June 2007 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY 13711 Darnestown Road Gaithersburg | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) | Hours | Min. | Nov. 19 9. Birthplace (State or Foreign 6. Sex Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year Maryland M 2 ☐ F 79 218-24-6537 Director Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Gaithersburg 1 □Yes X□No a or 28a-f sh t be notified MD Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20878 U.S.A. 13701 Darnestown Road traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XNever Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 2 yrs Elementary/Secondary (0-12) Produce Dept. Giant Foods 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Genevia Rosev Earl Washington, Sr 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13711 Darnestown Rd, Gaithersburg, MD 20878 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr. Steve Marlin (POA) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal From State Pleasant View Cem 6/9/07 Gaithersburg, MD 4 □ Denation 5 □ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Sign tvr. of Funeral Service Lice 246 N. Washington St, Rockville, MD 20850 eath. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death complications that caused the only one cause on each line. 23a: Part1. Enter the disease shock, or heart failure. ease, or Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of): Examiner Respiratory Failure Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 I Inknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Tes 2 No 3 Probably 4 No Nown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has I autopsy performe certificate 1∐ Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death Check onl one Be ınıormant Other: 4 Nursing Home 5 Residence 6 Other (Specify) Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death the 1 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral I

completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D0064615 6/6/07 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1355 Piccard Dr, Rockville, MD 20850 Genevieve Wroblewski, M.D. ∰gistrar's Signature 31. Date filed (Month, Day, Year) State 13 2007 JUN Registrar

			State of Maryland / Departmen	t of Health and Me of Death	Mental Hygic	ene 007	20835
п	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		James Walter Wilson		June	1 2007	6:30 PM
	Examin	er		Town, or Location of Death Easton		4c. County of Deat Talbo	
	Funeral		Social Security Number		8. Date of Birth		hplace (State or Foreign
	Funeral Director		217-28-3482 1 M 2 F 74 Yrs. Months	Days Hours Min.	8. Date of Birth (Month, Day, Y	Gear) Co 032 Mar	yland
	P .		Usual Residence of Decedent				
	anyla ehov	_	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1 ☐ Yes 2 No
	28a-f	Director	Maryland Talbot Trappe 10e. Street and Number 10f. Zin	Codo	10-	Citizen of Michael Co	
	with with		· · · · · · · · · · · · · · · · · · ·	21673	Tog	o. Citizen of What Co USA	•
	me 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent	dent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	
9	ours after death with the Marylan rai, or iteme 23a or 28a-f e how Examinat must be notified at	큔	Armed Forces? If Yes, spec	cify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	e, etc.
93	72 hours after death with the Maryland natural; or iteme 23a or 28a-f ehow dical Examanar must be motified at	d by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	2 No Specify:		Specify:	Black
21215-0036	22 23	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of wo life. DO NOT us	rk done during most of work	ang 16	b. Kind of Business/	Industry
12	within ene. then "	E C	Elementary/Secondary (0·12) College (1·4or 5+) 8 Truck Dr	,		Granville	. Wise
9	E T T T	0	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		wise
lan		To B	Raymond Alexander Wilson, Sr.	Clara		Greene	
Maryland	d 2 should th and Men 7 ie marke traumatic			(Street and Number or Run	al Route Number, C		Tip Code)
	5 = N =			Street, East		and 21601	
ore	800-		20a. Method of Disposition 1	ne of I ther place)	Date 20	c. Location - City or	Town, State
Baltimore,	nit. Pagartmen ortant: injury e.		4 □Donation 5 □Other (Specify) Paradise Ceme		5-2007	Trappe, Ma	ryland
Bal	permit. Page Department of Important: If eny injury or		rammie y. Shaw 426	ie Smith Fune Dover Street	, Easton,		21601
П			23a. Part. Enter the disease, or combilidations that caused the death. Do not enter the mod shock, or heart failure. List only one cause op each line.	e of dying, such as cardiac	or respiratory arrest	1.	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Hensel cult cancin	ome with be	omy metas	1030	Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	d d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events				
Õ	ate be executed hysicien and he burial-transit		resulting in death) Last Due to (or as a consequence of):				
68760,	ate be hysici ihe bu	lical	d				
<u>3</u>	death certificat e ettending phy of for use as th	Physician/Med	IF FEMALE:				
Вох	ettenc for us	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic print past 12 months? 1 Pregnant at time of death 5 Other (sc			23d. Date of deli Month	very Day Year
P.O.	0 0 2	iysic	1 U Yes 2 No 9 Unknown 9 Unknown	ecity)			
	requires that the een signed by th hould be detache	by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying c	ause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
g	w require been sig should b		Myldiple myelom		1 🗆 Yes	2 □ No 3 □ Pro	obably 4 Onknown
000	aw 2 sl	ompleted	Mypoudcemia		24a. Was an autopsy	24b. Were au	topsy findings available
œ —	The ete h	Com	Anemia		performe	d2 death?	2 No
/ita	ysician: Th is certificete director, peg	Be	25. Was case referred to medical examiner?		h (Check only one)		
_	G o S	J.	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DC 27. Manner of Death 28a. Date of Injury 28b. Time of 2			ce 6 □Other (Spec	city)
Ö	Ing Witer Une	tion	Natural 5 Pending (Month, Day Year) Injury	!8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	0
Division of Vital Records,	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory		28f. Location (Stree	et and Number or Ru	ral Route Number,
ă	s efte	Certification:	4 ☐ Homicide determined building, efc. (Specify)		City or Town, S	State)	
	Nospitel or Attendi 124 hours efter death Prografice Fundation of Procestration of the files of	cal	29a. Certifier Check only (Check only 2 Medical Examiner: On the basis of examination and/or investigation	at the time, date and place, in my opinion, death occur	and due to the caus	se(s) and manner as	stated.
	# # # 8	Medi	and manner stated.				
	ナハセ ちょう	_	29b. Signature and title of certifier 29c	: License number	290	Date signed (Month	7
	LVI	7	30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)	Ymis		0.70	
	' 7		m	INS LANE	EASTO	MM M	21601
	Sta		31. Date filed (Month, Day, Year) 32 (legistrar's Signature)		,	
	Registr	ar	JUN 0 5 2007 Been & Jane				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Physician Regina Rose Waite 2007 2:30p 24 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 24790 Deep Water Point Drive Talbot St. Michaels If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 XF 267-28-7679 79 Yrs. Director Tampa. Fl. 8-19-1927 Usual Residence of Decedent the Maryland 10d. Inside City Limits worle 10a. State 10b. County 10c. City, Town or Location r then "naturel", or items 23a or 28a-f ehovine Medical Examiner riust be notified at St. Michaels 1X Yes 2 □ No Talbot Director Md 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21663 24790 Deep Water Point Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: if item 27 ie marked other then "naturel", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ð 3 XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registered Nurse years 12 Years of Health and Mental Hygie Item 27 is marked other other traumatic event, it 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Helen Smith Reginald Wyckoff Perkall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles Paul Waite (son) 103 Boundary Lane, St. Michaels, Md.21663 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 'Department of H Important: if ite eny injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Cemetery 6/26/2007 Arlington, Va. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
R. Carroll Hurley Funeral Home, PC 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the heath. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Immediate Cause (Final Approximate Interval Between Onset and Death Immediate Cause (Final 4 Hours **Physician** HILLURE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 10 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner ending physician and use as the burial-transit or Attending Physicien: The law requires that the death certificate be executed EROSIS, GENERALIZED LOYears that initiated events resulting in death) Last Box 68760. loyears PIDEMA Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ Yo 3 □Ectopic pregnancy Month Year 4□Pregnant at time ol death 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 5 Pending investigation after death.
I Director: Aff 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 060300 May 31,2007 4+VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1013 S. Talbot St., St. Michaels, Md. 21663 Jr. Joseph A. Besso,

DHMH 17 Rev 1/2001

Registrar

31. Date liled (Month, Day, Year)

MAY 3 1 2087

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** Olive Wagener June 17, 2007 8:25 pm Nancy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Solomons Nursing Center Solomons Calvert 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) . Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🗓 F Director 460-30-1082 81 11/25/1925 Texas Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 'natural', or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Hollywood Maryland St. Mary's 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 45016 Steer Horn Neck Road 20636 United States Completed by Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) f Health and Mental Hygiene. Item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ဂ Herbert K. Caldwell <u>Margaret McManus</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45016 Steer Horn Neck Road, Hollywood, MD e of Disposition (Name of Date | 20c. Location - City or Town Barbara Rowell/Daughter 20636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Ebenezer Methodist Cm 06/22/2007 Great Mills, Maryland Simulation of uneral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 🗌 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1∐ Yes **©**XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Sursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes ⊗ No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No s after death. 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 ☐ Homicide within 24 hours a 29a. Certifier DECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0

Registrar DHMH 17 Rev 1/2001

State

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

110

Registrar's Signature

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JWYneth 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death **Physician** 7:20 aM June 2007 Walter H. Young, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Washington Adventist Hospital Takoma Park If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. Country. 1X M 2 □ F 578-40-5275 75 February 18,1932 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Ħ a or 28a-f sho t be notified a 1 ☐ Yes 2 ☐ No Director Prince George's **Hyattsville** Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a 20783 U.S.A. is marked other than "natural", or items 23a aumatic event, the Medical Examiner must 1107 Raydale Road Funera filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Electrician Electrical permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event; 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil tment of Health and Mental H tant; If Item 27 is marked ott Be Ruth Ella Gray ဂ္ William Lewis Young 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Rose Young - Wife 1107 Raydale Road, Hyattsville, Maryland 20783 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery 6/15/2007 Adelphi, Maryland 22. Name and Address of Facility Signature of Funeral Service Licenses Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each fire. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequer **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner the death certificate be executed that initiated events resulting in death) Last signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 2 No 9☐ Unknown 9 ☐ Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, <u>}</u> 4 Unknown 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 2 No 2 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner - Teath 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 atural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, who completed cause of death (Item 23a) (Type, Print) 30. Name and address of erson 31. Date filed (Month Registrar's Signature Year State Registrar

07-04385

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2007 20839

ndra Dodge Zin	1-	For State	Certi	ificate of [Death		2 Date	Reg. No		3. T	ime of Death
Physician	n/ 1.	Decedent's Name (First, Middle,Last)					Mont	h Day 8, 2007	y Year	0	943 hrs
Examin	er	Sandra Dodge Zim Facility Name (if not institution, give stree	merman and number)	4b	. City, Town, or Lo	ocation of D	eath		4c. County o Calvert	Death	
		8341 Quince View Lane			Owings	If Under 2	4Hre Is Da	te of Birth(M	M/DD/YYYY)	9. Birthpla	ce (State or
Funeral Director	- 1	Social Security Number 6. Sex 102-34-7705 1 M 2	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days			3/12/		Foreign	NY
		sual Residence of Decedent		Town or Locatio	in.						d. Inside City Limits
w any	1	0a. State 10b. County			Owings						X Yes 2 No
land f shov	ē L	MD Calvert Oe. Street and Number			10f. Zip Code			10g.	Citizen of Wh	nat Country?	,
r 28a	Director	8341 Quince View	T _i ane	l		736			USZ		District.
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once, injury or other traumatic event, the Medical Examiner must be notified at once.	틸	1 Marital Status 12.	Was Decedent Ever in U.S	S. 13. Was	Decedent of Hisp es, specify Cuban,	anic Origin Mexican, F	? (Specify Y uerto Rican,	es or No- etc.)		- American e, etc.	Indian, Black,
death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	1 Never Married 2 Married	Armed Forces? Yes 2 X No						Specify:	Whi	te
after d al", or	by F	3 Widowed 4 X Divorced If Yes	, Give Year	16a Doceden	Yes 2 X No t's Usual Occupati	on (Give kir	nd of work do	one 16	6b. Kind of Bu		
hours natur Exam	ed	15. Decedent's Education (Specify only hig Elementary/Secondary (0-12)	College (1-4 or 5+)	during me	ost of working life.	DO NOT u	se retired)		Μ-		
36 nin 72 than "	E E	Elementary/Secondary (5 12)	2	Marin	na Mana	ger		Middle Mai	den Surnam	rina	
ed with	Completed	17. Father's Name (First, Middle, Last)							den Soman	٥,	
215 be file ental H rrked vent, t	å	Lawrence Dodge 19a. Informant's Name/Relationship (Type,	Print \	19b. Mailing	g Address (Stree	G1 L0	da Mo per or Rural F	Route Number	er, City or To	wn, State, Z	ip Code)
D 27 should and Mo 7 is m	10	Trevor Zimmerman	/Can	397 N	Mission	Roa					
and 2 sealth 2 tem 2 traum		20a Method of Disposition	206.	Place of Dispos crematory or ot		metery,					
OFE iges 1 it of H t: If i		1 X Burial 2 Cremation 3 X F 4 Donation 5 Other Specify:		irfax	Mem. P	ark	6/13	/07	Fair	ax,	VA
nit. Pa artmet sortan ury or		21. Signature of Funeral Service Licensee	1	22. 1	Name and Addres	s of Facility	Raym	ond-W	lood I	Г.Н.,	P.A.
Ba pern Dep Imp		23a. Part I. Enter the disease, or complication	/ d the doot	P(OB 430,	Dun I	KITK, ardiac or resp	oiratory arres	st, shock, or h	eart	Approximate Interv Between Onset ar
hysician		failure. List only one cause on each i	116.	n. Bonet en							Death
Medical ≝xaminer		Immediate Cause (Final disease or condition resulting in death)	Itiple Injuries to (or as a consequence	of):							
		b.									
	ner	if any, leading to immediate Due	to (or as a consequence	of):		11					
	Examine		e to (or as a consequence	of):							
ecuted and transit		d									
), be ex sician urial	ij	UNITERBLE	MENDED 23c. If yes, outcome of pro	egnancy					1	of delivery	av Year
876(ifficate	Ž	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live birth	2	0.01	Ectopi	c pregnancy		Monti	ı D	ay Year
Box 6876 e death certificate the attending phy	sician/N	1 Yes 2 No 9 Unknown	Pregnant at time of Unknown	death 5	Other (Specify)						
. Bo the dea y the a	Phys	Part II. Other significant conditions		t resulting in the	e underlying caus	e given in P	art I.				the cause of death?
P.O.	2)						24a. Was			topsy findings avail.
ds, require	Completed							autop		prior to o death?	completion of cause
e law 1	a Se 2 su							1 Yes		1 🗸 Ye	es 2 No
- Re	tor, pag	25. Was case reletted to modical				Other	h (Check onl		Residence	6 Other	r: Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death.	direct	examiner?	spital: 1 Inpatient 2	ER/Outpati 28b. Time		njury at Wo	rk? 28	d. Describe	how injury or	curred	
of of ing Ph	uneral		28a. Date of Injury (Month, Day, Year) FOUND:	FOUND:	1	Yes 2	✓ No la	wn tractoi	raccident		2
sion ttendi death.	y the f	1 Natural 5 Pending 2 Accident Investigation	lun 9 2007	0943 hrs At home, farm, s	street, factory, offic	ce building,		or Town	State)		ural Route Number,
Jivis all or A safter	filled in by the fune	3 Suicide 6 Could not be determined	(Specify) Single F	amily			83	341 Quince	View Lane		
Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys.	ely fill				ccurred at the time	e, date and	place, and di	ue to the cau	ise(s) and ma e and place.	anner as sta and due to t	ted. he cause(s)
the H	mplet	one) 2 Medical Examiner:	On the basis of examination of the basis of examination of the basis o	on and/or inves	ugation, in my op.	cense numb					onth, Day, Year)
الم الم	3	29b. Signature and title of certifier	0_			.C.M.E.			June 9	-	
		Josh ?	Jeen m								
2K		30. Name and address of person who can Tasha Greenberg MD.	ompleted cause of death (ssistant Medical Ex	^(Item 23a) kaminer 1	111 Penn Stre	et, Baltir	nore, MD	21201			
25		Tabila Crossing	22 Defetrar's Si	nature	A						
Bo	Sta gistı	te 31. Date filed (Month PNYe 1) 1 2	007 Se Rossianos	, St.	Courses						

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Arnold Gerard Ziegler 10, 2007 June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☑ M 2 ☐ F **Director** 028-12-8073 Feb. 16, 1926 Massachusetts Usual Residence of Decedent Maryland 10a. State 10h Counts 10c. City. Town or Location 10d. Inside City Limits show r 28a-f shov notified at 1 □Yes 2 TXNo Director Maryland Montgomery Silver Spring 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 11501 Lamberton Court 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1½ Yes 2 □ No If Yes, Give Year or Dates: 1943-74 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 and 2 should be filed within 72 hours after di-Health and Mental Hygiene. em 27 is marked other than "natural", or iter ther traumatic event, the Medical Examiner. Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify. Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) USMC/Law/Real Estate Elementary/Secondary (0-12) College (1-4or 5+) Colonel/Attorney/International Development 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arnold Ulrich Ziegler Mary Sylvia Day ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold Dennis Ziegler/Son 11501 Lamberton Court, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages jo = ò 1 Burial 2 □ Cremation 3 □ Removal from State Sept. 6, Department of Important: If any injury or once. Arlington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2007 | Arlington, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Leter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. CANCER Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of): Records, P.O. Box 68760. IF FEMALE 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has b irector, page 2 sl 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy 1∐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No 27. Manner of Dea h Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1. Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No lospital or Attend hours after death. uneral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

ivision or Vital

within 24 hours al 0+1

Medical

(Check only

JUN

29b. Signature and title of certifier

13 2007

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

5454 WISGNSIN AVENUE #1300 CHELY CHASE, MD KALIL, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature

Physic		Registrar 1. Decedent's Name (First, Middle, Las	State of Marylar ems 27,28a,b,c	reel	lineale 0	PDealii		Reg. 2. Date of Death	No.	Т	3. Time of Death
		Λ	mmon					Month		Year	0846 A
/Medi Exami		4a. Facility Name (If not institution, give			4b. City, Town	n, or Location o	f Death	00	4c. County of		0 940 1
and the same for the first	anel I	EAST POINT NUNSING	AND RETHABLU	Mion		timore				timor	e
Funeral	CIC	Social Security Number 6. Se	7. Age (In yrs.		If Under 1 Yes Months Day		24 Hrs. Min.	8. Date of Birth	ear)	9. Birthpla Countr	ce (State or Fore
Director		Usual Residence of Decedent	X M 2□F 73	Yrs.	World's Day	/s Hours	IVIII.	8. Date of Birth (Month, Day, Young 28,	1933	Counti	y) un
how	_	10a. State 10b. County		ty, Town or Lo	cation					100	d. Inside City Limi
S - S	cto	MD Baltimo	ore	Ba1	timore						1 ☐ Yes 2√
natural', or iteme 23a or 28a-f show	Director	10e. Street and Number			10f. Zip Code	9		10g	. Citizen of W	hat Countr	y?
23a	100	1046 Old Northpoi	nt Road			21224			U	ISA	
E E	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13. V	Vas Decedent of Yes, specify C	of Hispanic Original of the Hispanic Original	gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		- Americar , White, et	
o E	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 XNo If Yes, Give	1	☐Yes 2XIN	lo Specify:			Specify:	whi	t _e
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other		17. Father's Name (First, Middle, Last)			un	_	r's Name	(First, Middle, Mai		akery	un
Mental arked c	To Be										
f Health and Mental item 27 is marked o other traumatic ev	-	19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailin	g Address (Stre	et and Numbe	r or Rural	Route Number, C	ity or Town, S	State, Zip C	(ode)
Health a		Eastpoint Nursing	& Rehab	1				ad Balti			1224
		20a. Method of Disposition	20b. F	Place of Dispos	sition (Name of		Da		c. Location - C		
ent of nt: If if		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☒ Other (Specify)	mennovan nom Stare	зытычну, стат	natory or other p	nace)					
Derartment Importent: I Eny Injury o		21. Signature of Euneral S. v. e Licens Ron 2 L. S	the state of the s	22	Name and Add	tress of Faculity	, -				
Deca Impo any i		Ronald S.	wade, Director					655 W. B	altimo	re St	reet
_		23a. Part1. Enter the disease, or comp	lications that caused the deati	h. Do not ente	ltimore	ving, such as o	LZUI cardiac or	respiratory arrest		Α.	pproximate
E 1		shock, or heart failure. List only o Immediate Cause (Final	one cause on each line.							l ir	nterval Between Inset and Death
ysician Medical		disease or condition resulting in death)	a. Sque to (or as a conseq	un (Allino	ma at	- Ul	una		1	YEAR
aminer			Que to (or as a conseq	puence of):	Fa	- 1-				-	
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g phys as the	D										
attending pt for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna						23d. Date	of delivery	
atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		Ectopic pregnar Other (specify)				Mont	,	ay Year
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certificate rector, pag	Ö	25. Was case referred to medical				00 81	-10. 11	1 Yes 2 ₩	10 11	JYes 2	D No
	00	examiner?	Hospital:	EB/01:1	a 🗆 no. 1	\thon	-	Check only one	. 50		
irec irec	: To	27. Manner of Death	28a. Date of Injury	ER/Outpatient 28b. Time of				e 5 Residence			
∞ 5		1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. In	ork? □ Yes 2 □	_		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	•	
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iter death. Director: After this in by the funeral di	ertificatio	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify	,,			1				
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iter death. Director: After this in by the funeral di	edical	4 Homicide determined 29a, Certifier Chack Say 2 Medical Exami	building, etc. (Specify	wledge, death	estigation, in my	opinion, death	place, an	at the time, date	and place, an	id due to th	e cause(s)
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07-04764 State of Maryland / Department of Health and Mental Hygiene Robert Donald Augustine 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day June 22, 2007 1724 hrs **Medical Examiner** Robert Donald Augustine 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Harford Perryman 502 East Michaelsville Road 9. Birthplace (State of If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Country) Months Hours Mir 02/06/1950 Director 57 209-38-8166 1X M 2 F Vrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2 X No Perryman Harford MD 28a-f shov notified at once. Director 10a, Citizen of What Country 10e. Street and Number 10f Zin Code USA 21130 502 East Michaelsville Road 23a Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status must be White etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Married 5 Specify: White Yes, Give Year Yes 2X No specify 3 Widowed 4 X Divorced the Medical Examiner þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) filed within 72 hours during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) MD 21215-0036 Automotive Auto Body Work 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) event, t Gladys Fargerstrom Be Pages I and 2 should be finent of Health and Mental Robert Augustyniak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is m r traumatic e 609 Dogwood Avenue, Edgewood, MD 21040 Selena Raiber/Daughter 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State 6/25/2007 Baltimore, MD Department o Important: injury or oth Metro Crematory Donation 5 22. Name and Address of Facility nature of Funeral Servi Stallings Funeral Home, oad Pasadena MD a The the disease or completations that caused the death. Do not enter the mode of dying. Approximate Interval Part I. En **Physician** Between Onset and failure List only one cause of /Wedical Death Head injuries complicating cocaine use Immediate Cause Final disea Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last g physician and the burial - trans Physician/Medical UNPENDED AMENDED PII. 27, perME, C869, 7/25/07 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy Year 3 Ectopic pregnancy Month Day Live birth Fetal death Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Yes 2 No 3 Probably 4 ✔ Unknown Methadone treatment Completed 24b. Were autopsy findings available 24a. Was an this certificate has been prior to completion of cause of autopsy performed? death? ✓ Yes 2 Yes 1 🗸 Hospital or Attending Physician: 24 hours after death. 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 V Yes 2 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred After 27. Manner of Death Certification: Yes 2 X No Natural neral Director: / / filled in by the fi Pending Fnd 6/19/2007 unk 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 X Could not be Suicide 502 E. Michaelsville Rd. Perryman, M To the Hospital or within 24 hours at To the Funeral D determined (Specify) house Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. June 23, 2007 30. Name and address of person who completed cause of death (Item 23a) 19 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 31. Date filed (Month, Day, Year) 32. F State Registrar

DHMH 17 Rev 1/2001 OCME 2006

		For Amend Items 23a per dr.	and Den , 868 De	727707dhb tificate of De	lth and Me	ntal Hygie	ne . Na. 2 () () 7	20843
Physici /Medio		1. Decedent's Name (First, Middle, Last) CAROLYN		BERRY 4b. City, Town, or Loc	2.	Date of Death Month JUNE	Day Year 14 2007 4c. County of Death	3. Time of Death 9:50 P M
Examin - Funeral Director	*	S. 555 a. 555 a. 5	yrs. last birthday)	BALT I	MORE Under 24 Hrs. 8	Date of Birth (Month, Day, Young, 30,	N/A	nplace (State or Foreign untry) ryland
D	or	Usual Residence of Decedent 10a. State 10b. County 10c Maryland N/A	: City, Town or Lo					10d. Inside City Limits 1 HYes 2 □ No
th with the 23s or 28s	al Director	10e. Street and Number 4222 Thayer Court		10f. Zip Code 2122			U.S.A.	
be filed within 72 hours after death with the Maryland atal Hygiene. do other than "natural", or items 23e or 28e-f show svant. I've Medical Evanical months and illed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes, 2 Not tyes, Give Year or Dates:		Was Decedent of Hispa If Yes, specify Cuban, № 1 Yes 2 🔀 No S	nic Origin? (Specil lexican, Puerto Ric specify:	y Yes or No- can, etc.)	14. Race - Amer Black, White Specify: Wh	e, etc.
within 72 ho iene. r then "natur	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th	(Give	dent's Usual Occupation kind of work done durin DO NOT use retired) utician	n ng most of working	16	Beauty	•
nd 2 should be filed within 72 hours at lift and Mental Hygies 27 Is marked other than "natural", or retreumatic svent, in a Mudical Exam	To Be Co	17. Father's Name (First, Middle, Last) Clyde Berry		ng Address (Street and		s Nichol	Lson	Fin Code)
permit. Peges 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any njury or other treumatic svent, the Mudical Examinar must be notified at ance.		19a. Informant's Name/Relationship (Type, Print) Frances Berry / Mother 20a. Method of Disposition 1 Daurial 2 (XCremation 3 DRemoval from State)	1 W	est Conway	Street A	pt. 705	Baltimor	re, MD. 2120 Town, State
permit, Peges 1 ar Depertment of Hea Important: If item any injury or othe		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	1 2	Crematory 2.Name and Address o 001 Ritchie	6/18/ ^{f Facility} Gone Highway	ce Funer	Baltimore, ral Servic more, Mary	e, P.A.
Cate be executed Physician _/Medical Examiner but sician and Examiner s the purial-transit	edical Examiner	23 Part1. Enter the disease shock, or heart failure. List his one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a condition or condition or condition or condition or condition or conditions or condit	nsequence of):	ter the mode of dving, s Obstructive CARD A	uch as cardiac or ree Pullmary	espiratory arres	t. Se	Approximate Interval Between Onset and Death 2 DAY years
The law requires that the death certilicate be executed with the law requires that the death certilicate be executed as been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown 23c. If yes, outcome of pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
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To the Hospital or Attending Physicien: The law requires! within 24 hours eiter death. To the Funerel Director: Atter this certificete has been signs completely tilled in by the funeral director, page 2 should be	Certification; To Be	25. Was case referred to medical examiner? 1	At home, farm, s	ont 3 DOA Other: of 28c. Injury at Work? M 1 Yes	28 s 2 🗆 No	e 5 Residen	ice 6 Other (Spe vinjury occurred eet and Number or Ri	
the Hospital thin 24 hours e ths Funerel (mpletely tilled	edical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of m 2 Medical Examiner: On the basis of examiner stated.	y knowledge, dea amination and/or i	ith occurred at the time, nvestigation, in my opini	date and place, ar ion, death occurred	nd due to the cau d at the time, dat	use(s) and manner at te and place, and due	s stated. e to the cause(s)
To the To the Comple	Me	29b. Signature and title of certifier M			o 0 1		d. Date signed (Monto)	
()		30. Name and address of person who completed cause of death SADEKA SHAHAN1, 30 31. Date filed (Month, Day, Year) 32. Registrar's	01 5 F	HANOVE	STRE	EFT, B	ALTIMO	RE, MD 212
St Regist	ate trar	31. Date filed (Month, Day, Year) JUN 2 8 2007 JUN 2 8 2007	positi					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2007 Physician June 26, 2:20 A M Rita Virginia Buckingham /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Glen Burnie Anne Arundel Mariner Nursing & Rehab 8. Date of Birth (Month, Day, Year) 1917 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sev 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🔀 Min. Months Days Hours Oct. Maryland 89 213-10-9084 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1XYes 2 □ No Director N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2809 Washington Blvd. 21230 United States Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 ₩Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 'Health and Mental Hygiene. em 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sophia Memorial (Calendar) Michael Dillman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau 30 Walkway Court, Middle River, MD 21220 John Buckingham, Jr. Grandson 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Redeemer Cemetery 6-29-2007 Baltimore, MD 21. Signatur Funeral Scrate 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Parci oroma Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed as the burial-transit Due to (or as a consequence of): ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by , page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 2 No or Attending Physician: 26. Place of Death Check onl one 25. Was case referred to medical examiner? funeral director, Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient After this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

P.O. Box 68760, Division or Vital Records,

within 24 hours after death To the Funeral Director: filled in by Hospital completely the U

State

29a. Certifier (Check only one)

29b. Signature and title of certifier

Mirza Mohammed Nusairee 31. Date filed (Month, Day, Year)

JUN 2 8 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32 Registrar's Signature

and manner stated.

D004051

29c. License number

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

21061

1401 Madison Park STE #100 Glen Burnie, MD

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2 007 4:55 PM Physician Lee Alice une Betty /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Baltimore-Washington Hospital Ctr. Glen Burnie 8. Date of Birth (Month, Day, Year) AUG 2 1931 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🛛 F MD217-26-7833 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Director MD Howard Jessup 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20794 USA 7810 Clark Road, Lot D62 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Maryland State Elementary/Secondary (0-12) College (1-4or 5+) Government 12 Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Audrey Amelia Perone Ayers ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7810 Clark Road, Lot D62, Jessup, MD 20794 James E. Bray - husband altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 6/28/2007 Baltimore, MD 21. Signature of Euneral Service Licensee H. Williams 22. Name and Address of Facility Cremation Society of Maryland, 299 Frederick Road, Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cell Carcinoma Immediate Cause (Final disease or condition resulting in death) Small Lung Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to himselfits cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Little to (or as a nonsequence of) Examiner burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No certificate Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manno of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident hours after death uneral Director: 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours at To the Funeral C 1 Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier June 27, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & ospital Drive, Glen Burnie, MD.

Registrar

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2007

JUN 28

31. Date filed (Month, Day, Year)

32. Peristrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 27 2007 1:40 a В._ **Blackmon** June Martha /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis Anne Arundel 1103 Lake Heron Drive, Apt. TC If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 73 NOV 8 1933 Georgia 251-44-4869 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits sa or 28a-f show t be notified at 10a, State 10b. County 1 ☐ Yes 2X No Director Anne Arundel Annapolis 10g. Citizen of What Country? 10f, Zip Code 21403 items 23a USA "natural", or items 23a 1103 Lake Heron Drive, Apt. TC Funeral within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: <u>م</u> White 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) than Dietitian Healthcare permit. Pages 1 and 2 should be filed be partment of Health and Mental Hygin Important; If item 27 Is marked other any injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Bowen Zoe Pearl Fonclara ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 South Hampton Street, Anaheim, CA 92804 James Coulston - son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 6/27/2007 Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams Name and Address of Facility Cremation Society of Maryland, 299 Frederick Road, Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CIANCIEN **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 1☐ Yes 2ETNo director, 25. Was case referred to medical 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 6 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Certification: To funeral 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 Tes after death filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physiclan: within 24 hours a

To the Funeral I

completely filled

State Registrar

31. Date filed (Month, Day, Year)

Medical

29a. Certifier

(Check only

29b. Signature and life of certifier

29c, License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d Date signed (Month, Day, Year)

30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) BESTERIE NO YOUNDOUS WO 2140)

32. Redistrar's Signature

		1 - For State Registrar 1. Decedent's Name (First, Middle, La	State of Mary		•	icate of l		2.	Date of D	Reg.	No.	117	3. Time of Death
Physicia		Anthony Joseph Bolee							Month June	23,	^{Day} 2007	Year	12:58 A M
/Medica	-	4a. Facility Name (If not institution, given			4b	. City, Town, or	Location of				4c. County	of Death	
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Funeral Director		5. Social Security Number 6. S		n yrs. last birt		Under 1 Year onths Days	If Under 24 Hours	Min.	Date of Bi (Month, D	ay, Ye	ear)	9. Birthp Coun	lace (State or Foreig try) NY
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<i>'</i>		30. Name and address of person who	completed cause of death	(Item 23a) (Type, Print					_	1-/		
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470			Decedent's Name (First, Middle, Last,)					2. Date of Death Month	Day Ye	3. Time of Death
	Physicia /Medic	_	DEBORAH BAIR						JUNE 18	, 2007	9:29 A M
	Examin	7.	4a. Facility Name (If not institution, give					Location of Death		4c. County of D	
			SOUTHERN MARYLAN 5. Social Security Number 6. Se		TAL ^r . Age (<i>In yrs. l</i> a	a st hirthday)	CLIN'	ION If Under 24 Hrs.	8. Date of Birth	9.	GEORGE S Birthplace (State or Foreign
	Funeral Director			M 2030F		·8 Yrs.	Months Days	Hours Min.	(Month, Day, NOV . 23 .	rear)	PENNSYLVANIA
34	~ ~		Usual Residence of Decedent		140.00	7			11011 201	1000 1 1	10d. Inside City Limits
	anylan show d at	_	10a. State 10b. County DC			, Town or Loc SHINGT					1 Yes 2 □ No
	he Ma 8a-f s	Director			YVA	OHINGI	10f. Zip Code		10	g. Citizen of What	t Country?
	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show steal Examiner must be notified at	al Dir	1803 4th St., N.	N.	#B-2		20001			UNITED S	STATES
	r deat	Funeral	11. Marital Status	12. Was Deced Armed For	ces?	S. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
S	s afte ", or it (amin	by Fi	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Give Year or Da	-	1	☐Yes 2ENo	Specify:		Specify:	BLACK
3	e hour	be	15. Decedent's Edu	ıcation		16a. Deced	ent's Usual Occup	ation		6b. Kind of Busine	ess/Industry
<u> </u>	within 72 iene. • than "na the Medi	Completed	(Specify only highest grad	College (1-	4or 5+)	life. L	OO NOT use retired	iuring most or worr l)	ang		
7	ad wit	- O	12th					DOMESTIC	ne (First, Middle, M	DOMEST	'IC
ana	be file	Be	17. Father's Name (First, Middle, Last)						•	aiden Surname)	
<u> </u>	2 should be and Mental is marked (raumatic ev	၉	CARL E. BAIR 19a. Informant's Name/Relationship (7)	ino Print)		19h Mailir	a Address (Street		ATTERSON ral Route Number,	City or Town. Sta	ite. Zin Code)
<u>a</u>	d2sh than than 17 is n traun	3 3	HARVEY ROBINSON		D	1			SH., D.C.		
a)	ges 1 and 2 should be filed within 72 ho to f Health and Mental Hygiene. If item 27 is marked other than "natu or other traumatic event, the Merical		20a. Method of Disposition	110011	20b. P	lace of Dispo	sition (Name of natory or other place	i		0c. Location - City	
Ē	Pages nent of nt: If if		1 X Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from S			VAT. CEM.		/07	QUANTICO .	, VA
Saltim	permit. Pag Department Important: Il any injury o		21. Signature of Funeral Service Licen		lal	1 1	Name and Addre		CAPITOL		
	20280		23a Part 1 Enter the disease or comm	dications that ca	used the deat				N.E. WA		Approximate
			23a. Part1. Enter the disease, or dome shock, or heart failure. List only of Immediate Cause (Final	one cause on ea	ach line.	1 line	numodeh	1	1		Interval Between Onset and Death
	Physician / /Medical		disease or condition resulting in death)	a. Due to (or s a consequence		nummin	any or	narome		
	Examiner			h				, ,			
1	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	usnes of):					20
	ecuter ind transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	C	or as a conseq	uanca of):					
60,	cate be executed only sician and the burial-transit	<u></u>	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Due to (or as a conseq	derice or).					
6876U	icate physi	dical		d							
Rox	leath certific attending p I for use as t	N/M	IF FEMALE:	23c. If yes, out	come pf pregna	ancy	Totanio programo			23d. Date o	
	0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No		irth 2 ☐ Feta ant at time of d		Ectopic pregnance Other (specify)	y 		Month	n Day Year
<u> </u>	at the by th	hys	9 Unknown			anti an in Alan a		en in Dort I	230 Did tob	acco use contribu	ute to the cause of death?
Vital Records, I	The law requires that the de tte has been signed by the a bage 2 should be detached to	by	Part II. Other significant conditions of	ontributing to de	eath but not res	uiting in the u	nderlying cause giv	en in Part I.	1 □ Ye		☐ Probably 4 ☐ Unknown
Ö	w require been sign	Completed							24a. Was ar	24b. We	re autopsy findings available
2	The la te has age 2	l E							autops perforn 1□ Yes 2	ned? dea	or to completion of cause of ath? Yes 2
<u>a</u>		Be C	25. Was case referred to medical					26. Place of Dea	ath Check onl one		
	Physician: The lar r this certificate has ral director, page 2	To B	examiner? 1 ☐ 7 es 2 ☐ No	Hospital: 1 ☐ I	npatient 2	ER/Outpatier		4 Li Nui sing i	lome 5 ☐ Reside		
0	ng fte		27. Manner of Death 1 ☑ Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time o Injury	Wo		28d. Describe ho	w injury occurred	
<u>S</u>	or Attending Physician: ifter death. Director: After this certifica in by the funeral director, p	cati	2 Accident investigation 3 Suicide 6 Could not be		of injury . At h	ome farm st		Yes 2 □No	28f. Location (St	reet and Number	or Rural Route Number,
Division or	or Attencafter death Director; in by the	Certification:	4 Homicide determined	buildi	ng, etc. (Speci	fy)	reet, factory, office		City or Town	, State)	
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director; A completely filled in by the fu		29a. Certifier 1 Certifying Ph	ysîcian: To the	best of my kno	owledge, deat	h occurred at the to	ime, date and place opinion, death occ	i e, and due to the ca urred at the time, d	ause(s) and mann ate and place, and	ner as stated. d due to the cause(s)
	the H hin 24 the F	Medical	one)		ner stated.		29c, Licens				Month, Day, Year)
	vit To	-	29b. Signature and title of certifier	1/a Ame		and		55120		_	
•	·		30. Name and address of person who	completed cause	se of death (Iter	m 23a\ /Tuna	Print)			June 18)
0	2 Y		hi chard Palmer v	D 1324	Souther	avenu	e SE Suit	2 310 Wa	shington D	c ruosz	
		ate	31. Date filed (Month, Day, Year)	2007 32. 6	gistrar's Sign	ature	Coall 1		shinglon D		
	Regist	trair	301120	-001	A SHOW	200	A STATE OF THE PARTY OF THE PAR				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 9872 10-1-07 vt. State of Maryland / Department of Health and Mental Hygiene - State Amend #9 perFH G868 6/28/07 Obertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 25**,**2007 7:10 A. M JUNE BULLARD BRIDGET Μ. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL 514 SYLVIEW DRIVE PASADENA If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Massachusetts **Funeral** Months Days Hours Min 1 M 2 X Director APRIL 6, 1939 PENNSYLVANIA 36-3804 68 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at Director 1 ☐ Yes XIX No MARYLAND ANNE ARUNDEL PASADENA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a 21122 UNITED STATES 514 SYLVIEW DRIVE Pages 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: WHITE 3 Widowed 4 ☐ Divorced Year or Dates: Completed other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED HEALTH CARE NURSE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PETER H. FOLEY JOSEPHINE MARY O'REILLY ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBBIE HOFFMAN / DAUGHTER GLEN BURNIE, MD 606 MINNERVA RD. 21061 J.W.Z.17 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 'Department of H Important: If Ite any Injury or of once. 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY CATONSVILLE, MD J30 ... 21. Signature of Funeral Service Licensee S.E. GLEN BURNIE, MD Ebaug 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖺 No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 XI Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation (Month, Day Year) 1 XNatural 1 ☐ Yes 2 ☐ No 2 ☐ Accident I Director: d in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D31551 JUNE 25, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RUSSELL DELUCA, M.D. 301 HOSPITAL DRIVE GLEN BURNIE, MD

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 11:54AM BOOKER NUNG 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 3ENERAL 4.5PTIAL (ARY LAND N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours 1 M 2XX Director OCT 10 NEW YORK 1942 006-34-0608 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or Items 23a or 28a-f shore event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 MCMECHEN ST. **APT 706** 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ŽXNo Specify: BLACK þ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY PRIVATE 12th grade of Health and Mental Hyginitem 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BERNICE FELTON JAMES BOLAR ပ or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12735 Colima Rd., Lamirada, California 90638 Scott Booker/Son 20b. Place of Disposition (Name of CNK cemetery, crematory or other place) Date UNK 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State EWYORK, NEW YORK 4 Dopation 5 ☐ Other (Specify) ure of Funeral 7 rvice Lig 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVE., BALTIMORE MD., 21217 nt1. Enter the disease, or co shock, or heart failure. List of ipplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Immediate Cause (Final **Physician** ATRACRANIAL HEMORRITAGE 1-2 HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EMERGENCY PERTENSIVE Sequentially list conditions Examiner physician Physician/Medical ed by the detached Completed by Be Medical Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760. After within 24 hours after death

To the Funeral Director:
completely filled in by the

If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		etopic pregnancy ther (specify)		23d. Date of delivery Month Day Year
OBSTRUCTI	contributing to death but not resulting in the under		23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
CHRONIC OBS	TRUCTIVE PULMONA	RY DISEASE	24a. Was an autopsy penformed? 1[2 Yes 2 □ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
25. Was case referred to medical		26. Place of Death	(Check only one)	
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 DOA Other: 4 Nursing Hor	ne 5 🗆 Residence	6 ☐Other (Specify)
27. Mann of Death 1		28c. Injury at Work? M 1 Yes 2 No	8d. Describe how inju	ry occurred
3 ☐ Suicide 6 ☐ Could not be determined		, factory, office	18f. Location (Street a. City or Town, State	nd Number or Rural Route Number, e)
	nysician: To the best of my knowledge, death or miner: On the basis of examination and/or inves and manner stated.			
29b. Signature and title of certifier	0	29c. License number	29d. Da	ate signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

and address of person who completed cause of death (Item 23a) (Type, Print)

827 LINDEN

2. Registrar's Signature

DANIEL LEMKIN

JUN 2 8 2007

31. Date filed (Month, Day, Year)

		•	For State Registrar		S	tate of Ma	aryland		artment of F rtificate of				giene Reg. No.	007	20851		
	Physicia	an	Decedent's Name (First, Middle, Last)								2. Date of Dea Month	ath Day	Year	3. Time of Death			
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	Funeral		5. Social Security N		6. Sex		e (In yrs. la	ast birthday)	If Under 1 Year	If Unde	er 24 Hrs.	8. Date of Birt	h Vaorl	9. Birthr	place (State or Foreign		
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Z	2 shoul and Me is mark	은	19a. Informant's Na					19b. Mailir	ng Address (Street				er, City or To	wn, State, Zip	o Code)		
	1 and 2 : Health at em 27 is other trau		Maureen	Altob	ello -	- daught	er	9727	Avene1	Farm	Road,	Potom	ac, MD	2085	54		
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Baltimore,	permit. Pages Department of Important: If is any injury or once.		21. Signature of Fu	st	eyett	H/ Will			Crematic 299 Fred	ieric	k Road	d, Balt	ımore.	, Inc.	21228		
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Ö	al or a after	erti	4 Homicide determined building, etc. (Specify)							City or To	wn, State)						
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical C	29a. Certifier (Check only one)	1 Certify 2 Medica	ing Physici ai Examiner	ian: To the best On the basis of and manner si	of examina	wledge, deat tion and/or in	th occurred at the to evestigation, in my	ime, date opinion, d	and place, a	and due to the ed at the time,	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)		
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	5		30. Name and add	ress of perso	n who comp	leted cause of a	leath (item	23a) (Type,	Print) 8, Rac	evil.	(e, n	12083	2 67	HIRA	6 THAKINA		
ļ	Sta Regist		31. Date filed (Mor	JUN 2	r)	32. Figist	rar's Signa	iture	parle								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryand Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OG **Physician** Year. lan K 2:05 AM 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MI ich en OS Saltano 2 Bult mile 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 6. Sex **Funeral** Days Year) 1 □ M 20 F 68-1666 2 Yrs. **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside Oity Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? en 50 Funeral Was Decedent Eyer in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. þ Specify: Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", any injury or other traumatic event, the Medical Exagonce. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working tite, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 20 2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Edward Bazzemore Had 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Boone - mother Hadie md. opular Del To. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methed of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Western retronore 4 ☐ Donation 5 ☐ Other (Specify) 3 neral Service Home Balto, md. 2,229 Approximate Interval Between Onset and Death e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause an ach line. nter the disease or heart failure. Immediate Cause (Final 8mins Physician zarmous yems disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed and as the burial-tran Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 9☐Unknown signed by the a d be detached for 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No plnous 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy perform Vital Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 √No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To ō 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Division (Month, Day Year) or Attending Natural N 5 ☐ Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion doubter and the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 200 n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD2010 1212 0 M 32 Registral's Signature 31. Date filed (Month JUN 2 8 State 2007 Registrar

State of Maryland / Department of Health and Mental Hygiene ? 1 - State Ragistra Certificate of Death Rag. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4:30 PM M **Physician** June 15, 2007 Joshua M. Chamberlain /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Kensington Kensington Nursing & Rehab 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Aug 22, 19 Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number **Funeral** 1፟፟፟፟∭M 2□F 1937 Washington DC Director 577-50-9115 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State 28a-f show r than "natural", or Itams 23a or 28a-f shov the Magical Extrainer must be notified at 1 Yes 2 No MD Montgomery Kensington Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20895 USA 3000 McComas Avenue 12. Was Decedent Ever in U.S. Amed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 161-63 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. hours after 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: Specify: black Maryland 21215-0036 ð 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marked other than 12 laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fi h and Mental H 7 is marked of Leona Washington John Oston Chamberlain 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health at Important: If item 27 is any injury or other trau 829 Quincy Street NW #403 Washington, DC Hannah C. Phillips/sister Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State in/state * 4 ☐ Donation 5 🖾 Other (Specify) 21. Sign thus of Euneral Price Licenses Waye, 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG CANCER **Physician** /Medical OBSTRUCTIVE PULMONARY **Examiner** CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine physician and s the burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical attending pl IF FEMALE. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 DEctopic pregnancy 1 Live birth 2 ☐ Fetal death Year Month Day 4 Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2. No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Medical Certification: After Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6/21107 00057124 Beo, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , ROCKVILLE, Mg 20850 MEDICAL CENTER DR #201 Sperker 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 8 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State of Maryland / Department of The State Registrar Certificate of L		Cinaiii	Reg. No.	2007	20854				
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of I	Death NE E	2. Year 2. 200	3. Time of Death					
	/Medic	al	Grace Ilene Cass 4a Facility Name (If not institution give street and number) 4b. City. Town. or									
	Examin	er	4a. Facility Name (If not institution, give street and number) Saint Joseph Medical Center 4b. City, Town, or	Tows				timore				
	Funeral Director		5. Social Security Number 171–22–1657 6. Sex 1 Months Days 80 Yrs. 1 Months Days	If Under 24 Hrs. Hours Min.	8. Date of I (Month, Oct.	Dav. Year)	9. Bir Ci P	thplace (State or Foreign ountry) A				
	/land ow at		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits				
	e Man la-f sh tified	ctor	MD Baltimore Timonium			1 ☐ Yes 2 No						
	or 28	Funeral Director	10e. Street and Number 10f. Zip Code	000		10g. Citi	zen of What C	ountry?				
	eath v	eral	102 Treetop Court 21 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His If Yes, specify Cuba	093 ispanic Origin? (Spe	cify Yes or	No-	USA 14. Race - Am					
0036	be filed within 72 hours after death with the Maryland Hyglene. d other than "natural", or Items 23a or 28a-f show to other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by	Armed Forces? 1 □ Never Married X□ Married 1 □ Yes X□ No 1 □ Yes 2□ No	n, Mexican, Puerto Specify:	Rican, etc.)		Black, Whi	white				
ດ	72 rna dic	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired)	ation during most of worki	ng	16b. Ki	nd of Business	/Industry				
2	I be filed within 72 ntal Hygiene. ed other than "na event, the Medic	duuc	Elementary/Secondary (0-12) 12 College (1-4or 5+) 12 N/a Hoemmaker	,		Or	vn Home					
D	e filed Il Hygi other rent, tl	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Midd							
yland	2 should be and Menta Is marked raumatic ev	To B	Wilbert F. Uplinger	Lithy								
Mar	12 sho		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street a			-		Zip Code)				
e,	1 and Healtl tem 27		William G. Cass/husband 102 Treetop Co 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)		Date		cation - City o	r Town, State				
altimore,	Pages ent of nt: If II		1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley Mer	10/4//		Timo	nium,	MD 21093				
Balt	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic es once.		21. Smatus of Funeral S rvice Literaser 7 22. Name and Address	ss of Facility		laney	Valle	y, Inc.				
Ā	1		Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 23a. Part 1. Er er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause or each line. Approximate interval Between Onset and Death Onset and Death									
	Physician	1	Immediate Cause (Final disease or condition ASPIRATION FNEUMONIA		Cristi and Deau							
	/Medical Examiner		Due to (or as a consequence of): RECURRENT PLEURAL EFF	RECURRENT PLEURAL EFFUSION								
H,		je.		ence of):								
٧	ocuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
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68/60,	tificate be executed g physician and as the burial-transit	edical	d									
O. Box	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the bunal-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown	/		-	23d. Date of delivery Month Day Year					
٦.	w requires that to be signed by should be detact	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	en in Part I.				to the cause of death? Probably 4 ☐ Unknown				
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Vital		Be C	25. Was case referred to medical examiner?	26. Place of Deat								
	hysic this ce al direc	To	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	4 Li Nursing Fig				pecify)				
n C	ding P	ion:	27. Manner of Death 1 ★ Natural 5 Pending (Month, Day Year) 28. Date of Injury 28b. Time of Injury 28c. Injur 28c	ryat rk? Yes 2 □ No	28d. Descri	be now inju	ry occurred					
Division or	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Nu. City or Town, State)		Rural Route Number,					
	Hospita 24 hours Funeral	Medical C	29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time (Check only one) 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time (Check only one) 1 Medical Examiner: On the basis of examination and/or investigation, in my of and manner stated.	me, date and place, opinion, death occur	and due to	the cause(s ne, date an	and manner d place, and d	as stated. ue to the cause(s)				
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	/		Degrada Mello mo D41.	410		3/11	we 22"	0,2007.				
	5		30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)	April Speak tile in a Speak		. 1		6 E. 9 NOV				
		ate	JOGINDER F. MEHTA M. D. 7601 OSLER	DRIVE	rowso	N, I	MAKYLF	ND 21204				
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 1329 PM JUNE COUNTESS 2 10SEPH D. 2007 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner HOPKINS BAYNEW MEDICAL CENTE BALTIMORE CITY BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☑ M 2 □ F Months Director 53 JULY 16, 1953 MARYLAND 213-64-0461 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MARYLAND ANNE ARUNDEL LINTHICUM 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō 23a 400 HOMEWOOD RD. 21090 UNITED STATES Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 2 3 ☐ Widowed 4 X Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 in and Mental Hygiene. 7 Is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) LOAN OFFICER BANKING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BETTY GERTRUDE TRUITT JOSEPH HOWARD COUNTESS, JR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra LINTHICUM, MD 21090 400 HOMEWOOD RD. BETTY HOLLAND / MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition JUNE 26, 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Denation 5 □ Other (Specify) 2007 CATONSVILLE, MARYLAND METRO CREMATORY 21. Signature of Furnaral Service Licensee 22. Name and Address of Facility KIRKLEY-RUDDICK FUNERAL HOME, P.A. GLEN BURNIE, MD 21061 421 CRAIN HWY. SE; 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY **Physician** WEFKS /Medical Due to (or as a consequence of): Examiner NEUMONIA 2 WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit LUNG CANCER SMALL CELL 2 WEEKS Due to (or as a consequence of): P.O. Box 68760. ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown After this certificate has been signed by i funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an 2 No Division or Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar
DHMH 17 Rev 1/2001

State

EASTERN

AVENUE,

4940

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MORAVE

YAZMIN

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 06:02 AM Physician MARGIANA MATILDA CHARLES June 25 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) WEST INDIES 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F 88 5 1919 Director MAY216-21-0745 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ty∏Yes 2 No be notified Director 28a-f MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A.

14. Race - American Indian, items 23a if Health and Mental Hygene.

Item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must other traumatic event, the Medical Examiner must 5207 SAYBROOK RD. 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2**X**XIo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK ۵ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within . Department of Health and Mental Hygiene. Important: if item 27 is marked other than "i any Injury or other traumatic event, the Med gnote. Elementary/Secondary (0-12) College (1-4or 5+) 8th grade CIVIL SERVICE GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPH MINGO RUTH FRANCIS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Erma V. Charles/Daughter 5207 Saybrook Rd., Baltimore, Maryland 21206 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ANTIQUA, WEST INDIES MXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) SAWCOLTS METH. CH. CEM. 07-07-07 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 21. Signature of Funeral Service Lj 1206 W. NORTH AVE., BALTO., MD 21217 Approximate Interval Between Onset and Death implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Part1. Enter the disease, shock, or heart failure. L mmediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine that the death certificate be executed and the burial-trai resulting in death) Last (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? To the Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 | Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

60 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Month Year **Physician** KUBY 9:52 A.M 200.7 25 une /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner AGNES HOSPITA1 Baltimore 7. Age (In yrs. last birthday) if Unde 1 Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🔀 F Months Days 209-26-7346 Director APPSIL 25,1931 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Funeral Director 3ALTIMORE 10g, Citizen of What Country? 11.5.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1273 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ULIUS ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 424 71. Md. 21229 NANASSEH 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ARBUTUS, Md. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility BEVERIN D. CROMARTIE THS Jumpl Clomaitee 2700 Edmondson AVE. 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or s a consequence of): in Known /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Donknown 1 Tes 2 No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2[No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: Medical Certification: To 1 Tes 1 | Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Accident 5 ☐ Pending investigation To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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ı	Division		Decedent's Name (First, Middle, Last)		2. Date of DeathMonth Death	3. Time of Death				
	Physici /Medio		William		June 1	8 2007 18:97 1				
	Examin	er	4a. Facility Name (If not institution, give street and number) The Johns Hopkins Hospital	4b. City, Town, or Location of Death Baltmore cit	J 4	c. County of Death				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdo	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign				
	Director		216-86-3944 ¹ X ^M ^{2□ F} 37 Yrs	Months Days Hours Min.	Sept 2, 19	969 Maryland				
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Limits				
Many	Mary Febr	ţo	MD	Baltimore		1∑Yes 2 No				
	a with the	Funeral Director	10e. Street and Number 2817 Orleans Street	10f. Zip Code 21224	10g. C	itizen of What Country? USA				
Maryland 21213-5-0035 td 2 should be filed within 72 hours after death with the Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show ampringers if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show amply injury or other traumatic event, the Medical Exactlinat must be notified at ance.	ρ	11. Marital Status 1 \(\bigcap \text{Never Married} \) 2 \(\bigcap \text{Married} \) Married 3 \(\bigcap \text{Widowed} \) 4 \(\bigcap \text{Divorced} \) Divorced	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R □ Yes 2 ₩ No Specify:	ify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
	within 72 ho ene. than "natur re Medical	Completed	(Specify only highest grade completed) (G	ocedent's Usual Occupation ive kind of work done during most of workin e. DO NOT use retired)	unk 16b.	. Kind of Business/Industry unk				
ana	d be filed wintal Hygie	Be	17. Father's Name (First, Middle, Last) William H. Davis Sr	18. Mother's Name Bever1						
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	and 2 valth a 127 is		Shirley Fales/aunt 71	71 East Brook Avenue	Baltimor	timore, MD 21224				
Baltimore,	Pages 1 ament of He ant: If Item		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ○ Corner (Specify) in State	sposition (Name of Decrematory or other place)		Location - City or Town, State				
Balt	Departition Departition of the second of the		21. Signature of Eunoral Socice Licensee Rolladd S. Wade, Director	State Anatomy Board Baltimore, MD 2120		altimore Street				
8/60,	Physician /Medical Examiner but sicien and physicien and support of the physician street but street but side physicians it is supported by the physician street but side physi	dical Examiner	25a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation and the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
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<u></u>	Phy al this	٠ <u>.</u>	1 ☐ Yes 2 ☐ No ☐ Inpatient 2 ☐ ER/Outpa 27 Mapner of Death 28a. Date of Injury 28b. Tim	e of 28c. Injury at 2	8d. Describe how inj					
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2	Hospital (4 hours al Funeral D	Medical Cer	29a. Certifier (Check only (Ch	r investigation in my opinion, death occurre	d at the time, date a	nd place, and due to the cause(s)				
	o the ithin 2 o the omplet	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number	29d. C	Date signed (Month, Day, Year)				
)	⊢ s ⊢ ŏ		ANIL Trindade, Medical Doc	tor RES-000	Ju	ne 18, 2007				
			30. Name and address of person who completed cause of death (Item 23a) (Ty		- Marilo	und 21287				
	Sta		31. Date filed (Month, Day, Year) 32 Registrar's Signature	harles						
	Regist	ali	JUN 2 8 2007 Januar A. A.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** MARIAN J. DURNEY OOM 27 2001 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** GIEN Baltimore Washington Medical Center ANNE ARUNDE1 Buenie 8. Date of Birth (Month, Day, Year)
MAR. 28,1931 If Under 1 Year If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Set 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 X F PENNSYLVANIA 76 213-26-4993 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MARYLAND ANNE ARUNDEL MILLERSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 506 OLD MILL RD. 21108 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: þ 3 X Widowed 4 ☐ Divorced WHITE Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STORE MANAGER GROCERY STORE permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygin Important; if item 27 is marked other: any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 FRANK HURLEY RUTH JOHNSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN STITELY/DAUGHTER 69 PLEASANTHILL DR., ELKTON, MARYLAND 21921 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Methpd of Disposition JULY Date 1 ☐ Eurial 2 ☐ Cremation 3 ☐ Removal from State 2007 ANNAPOLIS, MARYLAND 4 □ Donation 5 □ Other (Specify) HILLCREST MEM. GARD. 22. Name and Address of Facility
KIRKLEY-RUDDICK FUNERAL HOME, P.A.
421 CRAIN HWY., S.E., GLEN BURNIE, 21. Signature of Funeral Service License MD 21061 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ver mon1 1 de Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No detached f Division or Vital Records, P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1□ Yes 2No 254No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3□ DOA Certification: To funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 (Month, Day Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death.

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letely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the l 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MN 200 lu URE MD address of person who completed cause of death (Item 23a) (Type, Print) en 10 Jashing ton Medica BUTA ie 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

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	th with the 23a or 28 ust be no	al Dire	10e. Street and Number 13 Talbott Stre	et		10f. Zip Code 21225			10g. Citizen of V United	State	es																							
	be filed within 72 hours after death with the Maryland tral Hygiene. A other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at event,	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 223 No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac Blac Specify	e - Americ k, White, Whi	etc.																							
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	5		30. Name and address of person who con Dr. Petr Hausne	mpleted cause of death (Item er 22 South	^{m 23a)} (Type, Greene	St. Bal	timore,	MD 2120	l																									

State Registrar

31. Date filed (Month, Day, Year) JUN 2 8 2007



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	*		Registrar 1. Decedent's Name (First, Middle, Last)		Tillicate of I	Jeani	2. Date of Dear	eg. No.	3. Time of Death					
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	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of De						
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	w w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits					
	Marylis f sho ed at	ō	Maryland Howard	CO	lumbia				1 ☐ Yes 2 No					
	the 28a-	Director	10e. Street and Number		10f. Zip Code		1	0g. Citizen of What C	country?					
	n with		6334 Cedar Lane		2	044		U.S.A.						
	death	Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Span Mexican Puerl	pecify Yes or No-	14. Race - Am Black, Wh						
9	or ite	/ Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【文 No — If Yes, Give)	1 ☐ Yes 2 X No	Specify:	o radan, etc.,	Specific.						
215-0036	ural";	d by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:	400 David	d#- 111 O	-11		VV.	hite					
5	n 72 '''nat edica	lete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wor. i)	king	16b. Kind of Busines	s/industry					
212	lene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+))	memaker	,		Own Ho	ome					
ğ	other ent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle, I	Maiden Surname)						
<u> a</u>	uld be Menta rked ric ev	To E	Hiram Spragging			Glad	lys Bleak	cley						
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	•	19a. Informant's Name/Relationship (Type. Print)					r, City or Town, State,						
≥,′	1 and 2 Health lem 27		Barbara Bednarzik (Friend)					.a, MD 210						
0	it of H		20a. Method of Disposition 1 ☐ Burial 2 反Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, crea	matory or other plac	1		20c. Location - City o						
altimore,	it. Pa rtmer rtant: njury		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Litensee	Metro Cre			3–2007	Catonsvil.	le, MD					
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.		M& K Haulen	- Š	Name and Address Vitzke Fur 5555 Twin	neral Hon KNolls F	mes, Inc. Road Colu	mbia, MD :	21045					
Г			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxima											
	Physician		Immediate Cause (Final disease or condition						Moulu					
1	/Medical Examiner		resulting in death) Due to (or as a	consequence of):	ntie				months					
ь	LXammer	_	Sequentially list conditions,	consequence of):	Chizop	hune	L		months					
8	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	consequence on).										
,	execunand and ai-tra	Examiner	that initiated events	consequence of):										
68760,	cate be executed physician and the burial-transit	edical												
w.			1-572											
õ	leath certifi attending I for use as	an/I	IF FEMALE: 23b. Was decedent progrant 1 ☐ Live birth 2		⊒Ectopic pregnancy			23d. Date of de						
P.O. Box	Attending Physician: The law requires that the death certif refeath. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 9 □ Unknown	me of death 5	Other (specify)			Month	Day Year					
<u>с</u>	hat the	P.	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?					
Records,	w requires that the de been signed by the should be detached	d by			,				Probably 4 ☐ UnKnown					
S	v requ	Completed					24a. Was a		autopsy findings available					
Re	he lav	dmo					autops	prior to death?	completion of cause of					
Vita	an: T tificate or, pe		25. Was case referred to medical			26 Place of Dea	1 Yes : th (Check only on	2	s 2 No					
>	hysician : The la nis certificate has I director, page 2	To Be	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Othe	or: /		ence 6 □Other (Sp	ecify)					
ō	ding Phy h. After thi funeral	n: T	27. Manuer of Death 1 Natural 5 □ Pending (Month, Day)		f 28c. Injur Worl			ow injury occurred						
<u> </u>	endlr sath. or; At	atic	2 Accident investigation		M 1 🗆	Yes 2 □ No								
Division or	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury building, etc.	y - At home, farm, str (Specify)	reet, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,					
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in by		29a. Certifier 1—Certifying Physician: To the best of	my knowledge, deat	h occurred at the tin	ne, date and place	, and due to the c	ause(s) and manner a	as stated.					
	ne Ho n 24 h ne Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of e and manner state	examination and/or in ed.	vestigation, in my o	pinion, death occu	rred at the time, d	late and place, and du	ue to the cause(s)					
	To the To the Comp	ž	29b. Signature and title of certifier		29c. License			9d. Date signed (Mor						
			& Son C		000	53 150) [June 27	7007					
	2		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type,	Print)	01-0:	Amad	June 27 Suite	110					
			31. Date filed (Month, Day, Year) 32. Applished	's Signature	اس مرا	nago	14000	Color	ntre					
	Sta Registr		ILIN 9 8 2007	H A				M	0 4045					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #31, per DVR, 8808, 6/28/0/II

State of Maryland / Department of Health and Mental Hygiene

1- For State Amend PI, line B PII, per MD 6808, 6/28/0/II

Reg. No.

Reg. No. 20063 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year Richard E Evans 6:39 PM June 2007 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of 5. Social Security Number Rathmore
If Under 1 Year | If Under 24 Hrs.
Months Days | Hours | Min. NIA Mamiand Medical Center 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Months Director 219-76-3580 48 18 1958 MARYLAND SEPT Usual Residence of Decedent death with the Maryland 10a, State 10h. County 10c. City, Town or Location 10d Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 □XYes 2 □ No Director MARYLAND BALTIMORE N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1515 CAREY STREET 21217 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of health and Mertal Hyglene. and the firen 27 is marked other than "natural", or liter any or other traumafte event, the Medical Examiner any or other traumafte event, the Medical Examiner. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2XXVo Specify Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME IMPROVEMENT 12th grade SELF 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT EVANS ဂ္ DORTS EVANS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Evans Jr./Son 1134 Gilmore St., Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2XX remation 3 ☐ Removal from State METRO CREMATORY 06-23-07 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 21. Signature of Service Ligens 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Diellen 1206 W NORTH AVENUE. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Anoxic Brain Injure
Due to (or as a consequence of): Anoxic /Medical Examiner Myocardial infarction Sequentially list conditions, if any, reading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) been signed by the s should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed' certificate 1∐ Yes 2 No or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2007 AU4176435517463 Tune 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Street, Baltimore, MD 21201 Reena Shah 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 25,27 per ME 0368 06/29/07dth

Or Charles of Manyland Department of Health and Mental Hygiene

Or Charles of Death

Reg. No.

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 21.58 PM Muriel B. Fecher JUNE 2007 /Medical 16 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MOSPITAL OF BALTIMORE BALTIMORE SINAT CITY If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 🛛 F Director 85 202-20-8317 Apr 18, 1922 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show at be notifled MD Director 1√2 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 "natural", or iteπs 23a dical Examiner must b 3308 Benson Avenue Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wi Department of Health and Mental Hygien Important: If item 27 is marked other th any injury or other traumatic event, the once. housewife own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Louis Burmeister Grace A. Allebach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHarlotte Gerczak/daughter 6115 Bellona Avenue Baltimore, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 21. Signature 1 Funeral Strates Licensee State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Chuse (Final **Physician** alle disease or condition resulting in death) 10 Days Thrive /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): 68760, attending physician for use as the buris Physician/Medical Box 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 1□Yes 2□No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 1∐ Yes Division or Vital **₽**Z No To the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral or 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1X Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES-000 analenota June 16, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOS PITAL BALTIMORE Bhanna Gupla SINAI OF MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Gorale Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month MINERVA MERLTON FAULCONER JUNE 2007 0658 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HEARTLAND OF SEVERNA PARK ANNE ARUNDEL SEVERNA PARK 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 201F **Director** 212.03.6146 97 NOV. 19,1909 VA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 2XX No MD ANNE ARUNDEL SEVERNA PARK 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 715 BENFIELD RD. 21146 USA 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Y Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2KKNo Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) TELEPHONE CO. MANAGER 12 C & P TELEPHONE CO. 12 should be filed w h and Mental Hygiel 7 is marked other th permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important; If Item 27 is marked other any injury or other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be FOLTON F. FAULCONER MARY JOHNSON ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT G. VALENTINE **NEPHEW** 549 CRESTPARK DR., GLEN BURNIE, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Kurial 2 ☐ Cremation 3 Removal from State LOUDON PARK CEMETERY 4 □ Donation 5 Other (Specify JUNE 28,2007 BALTIMORE, MD 21. Signatu 22. Name and Address of Facility FINK FUNERAL HOMÉ, P.A. GRECORY M01148 426 CRAIN HWY. S .. GLEN BURNIE. MD 21061 23a. Part1. Enter the dise so or conclications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ongest /Medical Due to for as a consequence of): Examiner Sequentially list conditions, if any, leading to in modula cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner be executed burial-transi Due to (or as a consequence of): Box 68760. physician Physician/Medical as the attending IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for (in the past 12 mor 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 performed Yes 2 certificate | Division or Vital 25. Was case referred to medical examiner? Assited Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No Hospital: 1 Yes P 1 🗌 Inpatient 2 ER/Outpatient 3□ D0A 6 Cher (Specify) 27. Manuer of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: Hospital or Attending 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 (Cycertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 860 ransttwu enniTer Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 21 Month **Physician** 2007 12:30 PM Phyllis Hambsch Field June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charlestown Care Center Catonsville Baltimore 8. Date of Birth (Month, Day, Year) 1. 1915 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country)
 New York 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1□M 2**X**F Director 218-10-7093 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. Slale 10b. County 10c. City, Town or Location 10d. Inside City Limits if Heelth and Mental Hygiene. Item 27 is marked other than "naturel", or items 23s or 28s-f show other treumatic event, the Mudical Examiner must be inclined at Maryland Baltimore Catonsville 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane #RGT224 21228 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ZX No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🗓 No Specify: 3♥ Widowed 4 Divorced ear or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Heelth and Merital Hygien importents if Item 27 is marked other this eny injury or other treumatic event, Ibas. Once. 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Philip Frederick Hambsch Helen Feldmeyer ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet F. Zerhusen Daughter 5055 Dry Well Court, Columbia, Maryland 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 06/25/2007 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Sign Ture of Funeral Service Livensee 22. Name and Address of Facility Witzke Funeral Home, Inc. 5555 Twin Knolls Road, Columbia, Maryland 21045 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final neumon19 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any loading to honordista-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner I Records, P.O. Box 68760, G burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ettending physicien Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant al time of death 5 Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 8 1 ☐ Yes 2 ₹ TNo 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate hes autopsy performed? 1 Yes 2 To the Hospitel or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Dale of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funerei Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) lilled in by 4 Homicide Certifying Physician: To the bast of my knowledge ideath occurred at the time, date and place and due to the cause(e) and make at stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 (9/2014 Marden Choice Lane 31. Dale filed (Month, Day, Year) 32. Agistrar's Signature State

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JUNE Pay 27, 2007 **Physician** 2:20A M Barbara Lou Gold /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 25 1925 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ F Director 82 472-22-4191 Minnesota Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show at other traumatic event, the Medical Examiner must be notified 1 ☐ Yes X☐ No Director Baltimore Lutherville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 3 any Injury or other traumatic event, the Medical Examinar minst han a 21093 USA 300 W. Seminary Ave. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Specify: white 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hilda Johnson William Paul Beinhorn 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9525 Bridgewater Ct. E, Frederick, MD 21701 Donald W. Gold/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD Metro Crematory 6/30/07 Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Euperal Service Licensee Michael J. Flagle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CORONARY ARTERY DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine death certificate be executed signed by the attending physician and d be detached for use as the burlal-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS 24a. Was an page 2 s autopsy this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury (Month, Day Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🛮 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 06-27-0

State Registrar

Oi

31. Date filed (Month, Day, Year)

FRANCIS KHOO

7601 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D.



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D30263

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MARYLAND

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			State Registrar			Cei	rtificate	of L	Death			leg. No:	JU/	20000			
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	Examin	C1	4a. Facility Name (If not institution		mberj		Randa			or Death			ltimore				
	Funeral		Northwest Hospi 5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1		If Under Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day			place (State or Foreign intry)			
	Director		216-34-5139	1□M 2\\ F	70	Yrs.	MONUTS	Days	riours								
and	A	-	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					10d. Inside City Limits					
Maryl	-1 sho	to	Maryland Howard		El	lkridge	<u>.</u>							1 ☐ Yes 2 🙀 No			
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ar dea	tems	Funeral	11. Marital Status	Armed F		J.S. 13.	Was Decede If Yes, speci	ent of His fy Cubar	spanic Ori n, Mexicar	igin? (Specify n, Puerto Ric	Yes or No- an, etc.)	14	Black, White				
36 Irs aft	r, or	by F	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, Gi Year or D	ve		1 ☐ Yes 2	X No	Specify:			S	pecify: Wh	nite			
:1215-0036 within 72 hours after death with the Maryland	satura Ical E	ted	15. Decedent	s Education		16a. Dece	dent's Usual	Occupa	ation	t of working		16b. Kind	of Business/Ir				
21. Ign 7.	en "r Med	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	e retired,)			Q=====	otana Ma	alon o I corr			
12 Z	fygier ther th nt, the		12 17. Father's Name (First, Middle, I	astl		Data	Entry		18. Mothe	er's Name (F	irst, Middle.			echnology			
Maryland 21215-0036 be filed within 72 hours at	ted of	To Be	Raymond Covey	2031/					Jean								
ary shout	mari umati	۴	19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Maili	ng Address		-		oute Numbe	r, City or 1	Town, State, Zi	p Code)			
and 2	n 27 l		Deborah Leopol	d- daught					re., 1	Elkrid							
Baltimore, permit. Pages 1 a	i of He if Item or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐Removal from	State	Place of Dispo cemetery, crei	matory or oti	her place	1	Date			ation - City or T				
tim F Pa	Department of Health and Mental Hygiene. Important; or Itams 23s or 28s-f show Important: If Item 27 is marked other than "natural", or Itams 23s or 28s-f show any Injury or other traumatic avant, the Medical Examination rust handlind at ones.		4 □Donation 5 □ Other (Sp 21. Signature of Furecal Service I		Mea	dowridge							idge, N				
B B	Depa Impo eny Ir		21. Signature of Pulled a Service of	MD1234		Ga 72	ry L. 250 Wa	Kau	ifman aton	"Funer Blvd.	al Hon , Elki	ne at ridge	MMP, MD 2	INC. 1075			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.										Approximate Interval Between				
Ph	nysician		trimediate Cause (Final disease or condition as BASRL BRTERY THROMBOSIS										Onset and Death				
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vision of Vital Records, P.O. Box 68 Attending Physiclen: The law requires that the death certifical	been signed by the attending phy should be detached for use as th	Completed by Physician/Medi	IF FEMALE:		tcome of pregn							23	d. Date of deliv	very			
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S, Tes th	igned be de	by	Part II. Other significant condition	_	leath but not re	sulting in the u	nderlying ca	iuse give	en in Part I	l.		bacco use es 2 🛭		the cause of death?			
Orc	peen s	eted	CHASTRO INTE	STIMITE	13 CE	0 6					24a. Was a	/		opsy findings available			
Division of Vital Records,	9 hes	idui									autop perfor	med?	prior to c death?	ompletion of cause of			
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ysic	direc	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital:	Inpatient 2	ER/Outpatie	nt 3 DO	A Othe	er: 4 □ Nι	ursing Home	5 🗀 Resid	lence 6	☐Other (Spec	ıfy)			
0 0 0	After thunera		27. Manner of Death 1 K Natural 5 □ Pendin	9	of Injury oth, Day Year)	28b. Time o Injury		Bc. Injury Work	C?		I. Describe h	now injury	occurred				
ision in the state of the state	death tor: /	icati	2 Accident investig	not be 300 Blac	e of Injury - At t	nome farm st	M factory		Yes 2		Location /S	Street and	Number or Ru	ral Route Number,			
Div Por	efter I Dirsc d in by	Certification:	4 ☐ Homicide determ		ling, etc. (Spec		ood, radiory,	011100			City or Tow						
ospite	within 24 hours effer death. To the Funeral Director: Affer this certificate hes completely filled in by the funeral director, page 2	edicai C	29a. Certifier 1 .Certifyin (Check only 2 Medical	g Physician: To th Examiner: On the l	e best of my kn	owledge, deat	h occurred a	at the tim	ne, date ar	nd place, and ath occurred	due to the o	cause(s) a	nd manner as	stated. to the cause(s)			
the	thin 24	Medi	one) 29b. Signature and title of certifier	and mar	ner stated.				e number				signed (Month				
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ORIGINAL

¹07-04668 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene James H. Green 1. For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month Day June 18, 2007 1855 hrs **Medical Examiner** James H. Green 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Prince Georges Hospital Cheverly Prince George's 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Directo 579-88-7827 36 July 18,1970 Country) Alaska 1X M 2 F Usual Residence of Decedent I0c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Waldorf Maryland Prince George's 1 X Yes 2 No or 28a-f show with the Maryland Director 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code #38 Brookside Place 20601 **United States** Funeral 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes 2XX No Widowed If Yes. Give Yea Yes 2 X No specify: Specify: Black 4 Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) . rages I and 2 should be filed within 72, iment of Health and Mental Hygiene.
Itani: If item 27 is marked other than "regor other transmatic." Elementary/Secondary (0-12) College (1-4 or 5+) 72 21215-0036 DOPS Inc. Twelve Truck Driver None 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James H. Green II Emma L.Milledge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD #38 Brookside Pl., Waldorf, Maryland 20601 Felicia Green/Wife Date 23, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, June crematory or other place) 1 X Burial 2 Cremation 3 Removal from State ment tant: Washington National 2007 Suitland Maryland Conation 5 Other Specify 5 ig ature of Funera 22. Name and Address of Facility Robert G. Mason Funeral Home Inc 1661 Good Hope Rd SE, Washington DC 20020 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that mitiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical attending physician or use as the burial -UNPENDED AMENDED The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death Month Day Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ⋧ Yes 2 ✔ No 3 Probably 4 Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) æ Other: examiner? Hospital: Inpatient 2 🗸 ER/Outpatient 3 Nursing Home 5 DOA Residence 6 Other this ို 1 V Yes After 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: Driver auto fixed object collision Jun 18, 2007 1624 hrs 1 ✓ Yes 2 Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide or Town, State) Route 301 S/B Viuale Dr., Upper Marlboro, Md. determined (Specify) Local Street Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the Hospital or Attending Physician: within 24 hours after death To the 1

Registra

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Ling Li, MD

and manner stated

32 Registrar's Signature

ORIGINAL

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 19, 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Statem 1-Maryland Appendment of Health and Mental Hygiene dr. 9868,06/26/0/dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June 2, Jean A. Hicks 2007 11:45 AMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Marley Neck Nursing & Rehab Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Ye Tune 11, 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours Min Year 1 ☐ M 2 🂢 F Virginia 226-26-4090 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturai", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits 1 ☐Yes 2√ No Director MDAnne Arundel Glen Burnie 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7575 E. Howard Street 21060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify white Specify: 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) unk 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur James Butcher Jr Sadie Bowie McKeown ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dorothy Wilt/sister 17 Bon Air Road Brooklyn Park, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ 9ther (Specify) 21. Sign ture of Europe Service Licenses Anald S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart dallure. List only one cause on each time. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) al Cinoma ola Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Examiner ed by the attending physician and detached for use as the burial-transi Due to (or as a consequence of) $\mathcal{Z}\mathcal{G}\mathcal{A}$ Division or Vital Records, P.O. Box 68760, IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Hinknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? res 2 N 10 or Attending Physician; funeral director, Be 25. Was case referred to medical examiner? 26. Place of - th Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) June 7, 2007

DHMH 17 Rev 1/2001

State

Registrar

AVE. Suite 231 Annapolis, Md 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 2 8 2007

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32. Registrar's Signature

ms 23a or 28a-f show must be notified at "natural", or items altimore, Maryland 21215-0036 ind Mental Hygiene.
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umatic event, the Mex

1 - For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** TANYA E. HARDY JUNE 24 2007 04:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4231 BONNER ROAD BALTIMORE 8. Date of Birth (Month, Day, Year) 11/28/1958 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 48 Months Days Hours Min. 1 □ M 2 🛣 F 216-62-6556 Yrs MARYLAND **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant if item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No MD N/A BALTIMORE Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4231 BONNER ROAD 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CUSTOMER SERVICE REP M&T BANK 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WINSTON HARRIS EVA JAMES ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DONALD HARDY / HUSBAND 4231 BONNER ROAD, BALTIMORE, MD 21216 permit. Pages 1 and Department of Healt important: if item 2 any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN CEMETERY 6/29/07 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Linter (disease, or complications that cause 100 e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or he at failure. List only one cause on each inc. Approximate Interval Between Onset and Death **Physician** year disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23h. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 5 Other (specify) 9□Unknown 9 Dunknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an pate has by page 2 s autopsy within 44 hours after upon...

To the Funeral Director: After this certuing

To the funeral director, To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ 28a. Date of injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death

State

Registrar

31. Date filed (Month, Day, Year)

JUN 28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 25, **Physician** 2007 Berv1 Harris 4:55PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General Hospital 8. Date of Birth (Month, Day, You Oct. 10, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1914 Days Months Hours 1 ☐ M 2 ☐ F Yrs Oct. 92 Director 578-24-0958 Washington, D.¢ Usual Residence of Decedent 10b. County 10c. City, Town or Location la or 28a-f show t be notified at 10d. Inside City Limits 28a-f show 1 √Yes 2 No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 3407 Chiswick Ct. #2F 20906 U.S.A. by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Yes 2√No Specify Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Washington News Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Winkelman Katie Somers 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph M. Laun(Great-Nephew) 8515 Thames Street Springfield, Virginia 22151 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State June 29. 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery SUitland, Maryland 21. Signature of Funeral Service Licensee 2007 22. Name and Address of Facility Lee Funeral Home, Inc. 20735 6633 Old Alexandria Ferry Road Clinton, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia 2 hours /Medical Due to (or as a consequence of): Examiner Septic Shock 1 hour Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has t autopsy certificate 1□ Yes 20 No 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 2∏ER/Outpatient 3 DOA မ 1 Inpatient this After thi funeral (27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Medical Certification; 5 ☐ Pending investigation 1 X Natural (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: The law To the Hosping.

Within 24 hours after death.

To the Funeral Director: After a small of the funeral by the further the funeral by the further the fur

29b. Signature and title of certifier W.O. Ferm

6 Could not be

determined

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29c. License number D31915

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) June 27, 2007

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3305 N. Leisure World Blvd. Silver Spring, MD 20906-1367 Warren Ferris, M.D.

State Registrar

31. Date filed (Month, Day, Year) JUN 2 8 2007



28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician certificate this After t Director:

Baltimore, Maryland 21215-0036

the Hospital or Attending Physician: the Funeral

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

JUN 2 8 2007

ca

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L. SEENIVASAN, MD 3001. S. HAMOVER St. BALTIMORE, MY 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 23 45 PM HANCOCK 2007 25 JUNE 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 07-01-1921 (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Days 1**⊠**M 2□F 228-16-6101 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 TYes 2 No TURNER STATION BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 215 CHESTNUT STREET Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII Black White etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married BLACK 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) POSTAL SERVICE MAIL PERSON 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GENEVA NOWLIN CHARLIE HANCOCK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 215 CHESTNUT ST., BALTO., MD 21222 MICHAEL HANCOCK/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) HOLLY HILL MEM. GARD. 06/30/2007 BALTO., MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H. INC of Funeral Service Licensee 1701 LAURENS ST., BALTO., MD 21217 4□Pregnant at time of death 5 ☐ Other (specify)

Physician /Medical **Examiner**

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has

The law requires that the death certificate be executed

or Attending Physician:

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

10a. State

Funeral

Director

"natural", or items 23a or 28a-f show edical Examiner must be notified at

is marked other than "natur aumatic event, the Medical

permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any Injury or other trau

Director

Completed by Funeral

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and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.

Baltimore, Maryland 21215-0036

Physician/Medical Examiner Completed by Be ٩ Certification:

11

23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line.	Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. GASTROINTESTINAL HEMORRHAGE Due to (or as a consequence of):	IMINUTE
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. COHGULOPATHY Due to (or as a consequence of):	3 DAYS_
Cause. Enter Orderlying Cause (Disease or injury that initiated events resulting in death) Last	c	
	d	
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23d. Date of delivery Month Day Year

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 □ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 1 Inpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manger of Death 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

29b. Signature and title of certifier

MEDICAL DOGOR

RES-000

29c. License number

29d. Date signed (Month, Day, Year) JUNE 26, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EASTERN AVENUE, BALTIMORE, MD, 21224 4940

MALLIK MAJNUDAR 31. Date filed (Month, Day, Year)

JUN 2 8 2007

Registrar

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			State of Maryland / Depa			9		
				tificate of Death		. No. 2017 20875		
	ıysici: Medic		Llwellyn Holmes		2. Date of Death Month	Day Year 3 30 PM		
	camin	- N	4a. Facility Name (If not institution, give street and number) SNAM HOSEITH OF BRUNNINE	4b. City, Town, or Location of Death Brande OM		4c. County of Death		
	neral ector		5. Social Security Number 150-24-8895 6. Sex 1 □ M 2 ▼ F 7. Age (In yrs. last birthday) 75 75 75	If Under 1 Year If Under 24 Hrs	8. Date of Birth (Month, Day, Y Aug 25,	(ear) 9. Birthplace (State or Foreign Country) New Jersey		
Maryland -f show	fled at	tor	Usual Residence of Decedent			10d. Inside City Limits 1∑∏Yes 2 □ No		
with the	be noti	Funeral Director	10e. Street and Number	10f. Zip Code 21215	10g	Citizen of What Country?		
death v	r must	neral	2525 W. Belvedere Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,		
5-UU36 72 hours after death with the Maryland natural", or items 23a or 28a-f show	or other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Yes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	☐ Yes 2 💢 No Specity:		Black, White, etc. Specify: black		
215-(17 1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ent's Usual Occupation kind of work done during most of worki OO NOT use retired)	ng 16	b. Kind of Business/Industry		
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Ce, Marylan 1 and 2 should be Health and Menta tem 27 is marked	er traumat			ural Route Number, City or Town, State, Zip Code) ue Baltimore, MD 21207				
altimore, mit. Pages 1 a partment of He portant: If item	ny or othe		4 Donation 5 Women Specify in State	sition (Name of Datory or other place)	ate 20	c. Location - City or Town, State		
Dairin Pages permit. Pages Department of Important: If It	any inju		21. Signature of Funeral Service licensee Ronald S. Wagte Director St. Ba	Name and Address of Facility ate Anatomy Board 1t Amore, MD 2120		Baltimore Street		
Physic	cian	7.29	23a. Part 1. Enter the disease, of complications that caused the death. Do not enter shock or heart failure. List only one cause on each line. Immediate Cluse (Final disease or condition	er the mode of dying, such as cardiac o	r respiratory arrest	Approximate Interval Between Onset and Death		
/Med Exam			Due to (or as a consequence of):	/				
D.	sit s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	2.				
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rdS, F. quires that t n signed by	ld be deta	٦	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		cco use contribute to the cause of death? 2 □ No 3 □ Probably 4 ⊡tonknown		
TECOLOS, The law requires te has been signer	age 2 shou	Completed			24a. Was an autopsy performe			
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g Phys	ieral dir	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of		ne 5 Residence 28d. Describe how	ee 6 □Other (Specify) injury occurred		
UNISION OF VILLING TO THE INC. To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has	n by the fur	Certification:	1	M 1 ☐ Yes 2 ☐ No	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)		
Spital of hours af ineral D	y filled is		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death					
the Hothin 24 I	mpletel	Medical	(Check only one) 2	29c. License number		. Date signed (Month, Day, Year)		
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			30. Name and address of person who completed cause of death (Item 23a) (Type, F	Print) OF BRANKINGS				
, De	Sta egistra		31. Date filed (Month, Day, Year) 22. Registrar's Signature	C o				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 23e per doc g869 7-5-07 vt. State of Maryland Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Virginia L. Ingle 26 9:25 A M 2007 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 4427 Ebenezer Rd. Perry Hall If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days 1 □ M March 13 1922 85 Missouri Director 430-20-0190 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a State 10b. County r 28a-f show notified at 1 ☐ Yes 2 ☐ No Funeral Director MD Baltimore Perry Hall 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number be r 21236 USA 4427 Ebenezer Rd. permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If tem 27 is marked other there any Injury or other traumation. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes & ☐ No Specify Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 12 n/a Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irma Wendel Thomas Wayne Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4427 Ebenezer Rd., Perry Hall, MD 21236 Richard Ingle/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 6/29/07 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Memorial Gardens Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 21. Senature of Funeral Service Licenson

Michael J. Flagle 23a. Part1. Enter the disease, or complicating that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Parkinson's I year **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Each of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably → Tonknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the mospies.
within 24 hours after death.
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0059385 which we White Marsh, MD 21237 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) White Square Bldg., 9105 Franklin Square Dr., Suite 312 Joseph Fuscaldo, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2007 Joseph Judge Sr. June 21 1:34PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Howard Columbia 6349 Amherst Avenue 8. Date of Birth (Month, Day, Year) Oct. 7, 1928 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Months Days Hours Min. Washington, DC 1√2 M 2 □ F 78 Yrs 216-28-4917 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 1 ☐ Yes 2☐ No ral", or Items 23a or 28a-f st Examiner must be notified Director Columbia Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6349 Amherst Avenue 21046 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, GiveX 1 ☐ Never Married 2☐ Married 1 ☐ Yes 2 🛣 No Specify: White Specify: Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Home Builder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H sant: If Item 27 Is marked oth Be ೨ Leo F. Judge Marie J. Doeing 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 Is Barbara J. Judge Wife 6349 Amherst Avenue, Columbia, Maryland 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) = 8 Department of Important: If any Injury or once. Louis Cemetery 06/25/2007 Clarksville, MD 21. Signature of Fineral Service Licensee, 22. Name and Address of Facility Witzke Funeral Home, Inc. 5555 Twin Knolls Rd., Columbia, Maryland 21045 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): sician ar burial-t Box 68760, Physician/Medical the as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Funeral Director: itely filled in by the 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after 29a, Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

20

29b. Signatura

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filed (Month, Day, Year)

within 24 To the

DHMH 17 Rev 1/2001

CHMUTEL 32. Registrar's Signature

ORIGINAL

address of person who completed cause of death (Item 23a) (Tyge, Print)

10700

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Conrad Wheeler Jacobs 200 1021019 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne 6 120 Bur Balto.-Wash. Medical Center VII If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 6. Sex Birthplace (State or Foreign Country) Days 1⊠M 2□F 73 Yrs. Director 213-32-5015 Maryland Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or Items 23a or 28a-f ehow Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Glen Burnie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 314 Lindera Ct. 21061 death United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Peges 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No ģ Specify: White 3 ☐ Widowed 4 ☑ Divorced "naturel" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than " Elementary/Secondary (0-12) College (1-4or 5+) Business Owner 12 Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked ဥ Frank Jacobs Mabel Wheeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heelth i Andrea J. Hancock / Daughter 314 Lindera Ct., Glen Burnie, Maryland 21061 permit. Pages 1 end Depertment of Healti Important; If Item 27 eny Injury or other t once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State June 27. 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. Catonsville, Maryland 2007 21. Signa yre of Funeral Sen ice License 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and set the burial-trensit Due to (or as a consequence of). Physician/Medicai 98 esn IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ō in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by cete has been signated by page 2 should b TE Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 1 ☐ Yes 2 0 No 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Impatient Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending deeth. 1 Yes 2 No investigation М the within 24 hours efter deet To the Funeral Director; 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only ţ 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

of Vital Records.

Division

JUN 2 8 2007

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	Funeral		l '	6. Sex 7. Age 1 ☐ M 2 ☐ F	(In yrs. last t	oirthday) Yrs.	if Under 1 Months I	Year Days	If Under Hours	Min.	Date of Birt (Month, Da	v. Year)	Count		_
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To the	within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Me	29b. Signature and title of certifier		111		29c. 1	License	e number	/ 7 /	10	29d. Da	ate signed	(Month, I	Day, Year)	-
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	3		30. Name and address of person v	who completed cause of d	eath (Item 23)	(Туре,	Print)		a	1.0) /	43	-0 -	1	c, md	
	Sta	ite	31. Date filed (Month, Day, Year)		ar's Signature	011	MOL	IS E	H	UE, D	-1, 1	128	ひしん	e/ck	-) 111d	_
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Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Deat Examiner Northwest Hospital Center Baltimore Randallstown 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days Months 1 X M 2 □ F Yrs 84 Director DEC 15 1922 215-12-9887 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Director MD Baltimore Catonsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1305 Gatefield Road 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature!" any injury or other transmitter. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: <u>}</u> Specify: 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Assistant 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore City Assistant College (1-4or 5+) Elementary/Secondary (0-12) Public Schools Superintendent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Huntley ပ Howard Lloyd Virginia Gladding 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Iris Wicks Lloyd - wife 1305 Gatefield Road, Catonsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 6/28/2007 Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams ²² Name and Address of Facility Cremation Society of Maryland, 299 Frederick Road, Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Menmonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-trans Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perfor certificate Division or Vital To the Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 Department 2 ER/Outpatient 3 DOA To

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

24b. Were autopsy findings available prior to completion of cause of death? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3. Time of Death

7: u7

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2X No

Maryland

Black, White, etc.

White

21228

Day

Year

Approximate Interval Between Onset and Death

Vear

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ax/

After

death.

within 24 hours after death To the Funeral Director:

State Registrar

Certification:

Medical

31. Date filed (Month, Day, Year) 32.

and title of certifier

5 ☐ Pending investigation

6 ☐ Could not be

determined

27. Manner of Death 1 X Natural 2 ☐ Accident

3 ☐ Suicide

4 Homicia

Certifier

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nature

Rand, Randallstorn, ond 21133 gistrar's Signature

1101 Old Court

completed cause of death (Item 23a) (Type, Print)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

N36078

28a. Date of Injury

(Month, Day

ORIGINAL

2088 State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 **Physician** JUne 4, Harry L. Leef Sr 7:30 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 9526 Holiday Manor Road Baltimore Baltimore 7. Age (In yrs. last birthday)

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1. Age (In yrs. last birthday)

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North Day, Year)

North Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Director 217-14-9015 1919 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heelih and Mental Hygiene.
Important: If Item 27 is marked other then "naturel; or Iteme 23e or 28a-1 show any injury or other traumatic event, Ite Mudical Examiner must be notified at once. 10a State 10b. County 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9526 Holiday Manor Road 21236 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: ¹42-4 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♥ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 42-43 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Ellen Ruhl Charles Hoyer Leef 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Leef/spouse 9526 Holiday Manor Road Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Euneral Server Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ettending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> 1 ☐ Yes 2 Z No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate hes l director, page 2 s autopsy performed' 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes : After this certifical funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Wither (Specify) HOS pr 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Matural 5 Pending death. nerel Director: A filled in by the ft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide after To the Hospital within 24 hours a To the Funerel i completely filled Hospital 1) Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square Drive, Baltimore ND suit 301 Tolib 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 or Attending Physician: within 24 hours after deat To the Funeral Director:

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year) JUN 28

29b. Signature and title of certifier



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and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

756950

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5 2007 CHRISTINE MEANS JUNE 25 12:20PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A SINAI HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 78 220-74-7436 Yrs 4/23/1929 CAROLINA Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE CITY MD 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21215 USA 5044 PEMBRIDGE AVENUE Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married BLACK 1 ☐ Yes 2 ☐XNo Specify 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSE MEDICAL 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EASTER MILLS JULIUS MILLS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIMNITA E. SMITH/DAUGHTER 5044 PEMBRIDGE AVENUE, BALTIMORE, MD 21215 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/02/07 DRUID RIDGE CEM. PIKESVILLE, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 4600 LIBERTY HEIGHTS AVE, BALTIMORE, 23a. Par 1 Enter the discusse, or complications that caused the deat shurk, or heart fair re. List only one cause on each line. o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease Condition resulting in death) Due to (or as consequence of): abote Sequentially list conditions, if any leading to immediate Due to (or as a consequence of if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 3 □ Ectopic pregnancy Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ber tension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1□ Yes 2 🗖 Mo

Physician /Medical Examiner Examine

Physician

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Department of Health a Important; If Item 27 is any injury or other tra-

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Pages 1 and 2 should be

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Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

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23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown

25. Was case referred to medical examiner? 1 Tyes 2 1 27. Manner of Death

28a. Date of Injury 5 Pending investigation

2 ER/Outpatient 3 □ DOA 1 Innatient 28b. Time of (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

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(Check only

1 HNatural

2 ☐ Accident

3 ☐ Suicide

4 Homicide

1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier, Ukeea mo

6 ☐ Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UBEROL 4419

32. Registrar's Signature

State Registrar

24 hours a Hospital

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **Amend Item 26 per verb.**, **868**, **96**/28/9/dhb.

Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 06:30M 2001 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Date of Birth (Month, Day, Year) If Under 24 Hrs. **Funeral** Months Min 1 M 2 Director Usual Residence of Decedent M death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Examiner must be notified at 1 Pres 2 No Director MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15-A Funeral 2150 11. Marital Status . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ NO Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industr n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Saleson 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Be permit. Pages 1 and 2 should be in Department of Health and Mental Important; If item 27 is marked o Jei ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sla e, Zip Code) 30 Potomac Street Cumberland, MD Potomac Haven Assisted Living 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Hate haforas 4 Donation 5 □ Other (Specify) bard 21. Signature of Funeral Service Licenses Ronal d S Wa 22. Name and Adoless of Facility
State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 2.1a. Part I. Enter the disea e, or complications that caused the death. Do not should, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death r the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) ardvac **Physician** /Medical or as a consequence of) Examiner 0 80 Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner a consequence of been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II Other significant conditions contributing to death ut not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of After this certificate has autopsy perform death? 2 No 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Assisted 2 No 1 Tes 2 ER/Outpatient 3 DOA Certification: To Living 28a. Date of Injury (Month, Day Year) 27. Manne Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 atural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No s after death. 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 32. Registrar's signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh 868 6-28-07 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25 2007 **Physician** MARY VIRGINIA PARHAM 1945 JUNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1400 E. MADISON ST., APT. #301 BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 75 Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 24 □ F 213-28-3422 Director 5/26/1932 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f show Examiner must be notified at MD N/A BALTIMORE Director 1XYes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1400 E. MADISON ST., APT. #301 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry decedents usual Occupation
Give kind of work done during most of working
life. DO NOT use retired)
DOMESTIC WORKER Elementary/Secondary (0-12) College (1-4or 5+) CLEANING COMPANY is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WILLIAM PARHAM DILILA FAGANS ပ or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health at Important: If Item 27 is any injury or other trau CLEOPATRA MOBLEY/DAUGHTER 814 N. KENWOOD AVE., BALTIMORE, MD 21205 20b. Place of Disposition (Name of Micemeter) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MEM. 6/30/07 $\frac{\mathsf{KING}}{\mathsf{G}}$ WINDSOR MILL, MD PARK 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 dul 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD 23a. Part. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each tipe. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OPD /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Š signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has b irector, page 2 si perform 2.0 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: ours after death.
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Certification:

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State Registrar 31. Date filed (Month, Day, Year) JUN 28

30. Name and address of

nd title of d

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier (Check only

one) 29b. Signature

4 Homicide

5 ☐ Pending investigation

6 Could not be determined

2007



(Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

23a) (Type, Print)

1 ☐ Yes 2 ☐ No

1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

12056935

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28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** +. 14 PM Dolores Agnes Richardson 6 1000 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 220-38-6661 1 □ M 2 X F 64 08/05/1942 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 404 North St. SE USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M Cashier 10 Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Dudley Hyde Lola Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Clarence Richardson / Husband 404 North St SE, Glen Burnie MD, 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 06/29/2007 Elkridge, MD 4 ☐ Donation _ 5 ☐ Other (Specify) ^{22 Name and Address of Facility}
Gary L. Kaufman Funeral Home at MMP, INC.
7250 Washington Blvd., Elkridge, MD 21075 Signature of meral Service Lice 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DIREASI Physician 000 resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? res 25 No 1□ Yes Hospital or Attending Physician; director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 (Month, Day Year) 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide 24 hours a e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. within 24 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier WO 1st 1gran 500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 punny. 22 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2.4 **Physician** 2007 June 10:58 PM Joann Robinson /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Year) Days 1 □ M 2 🕅 F 56 577-76-5233 April 20,1951 Washington, D.C Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Columbia Maryland Howard 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number U.S.A. 5156 Flowertuft Court 21044 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Unemployed permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph N. Robinson, Sr. Annette Jasper ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5156 Flowertuft Court Columbia, MD 21044 Donald M. Wheeler (Friend) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6-27-2007 Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) Catonsville, MD Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, MD 21045 21. Signature of Funeral Service Licenses M01050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** months /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy perform 1□ Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the I 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles St SMC 6761 (1 31. Date filed (Month, Day, Year) 32 egistrar's Signature State JUN 2 8 200 Registrar

For State Registrar

Baltimore, Maryland 21215-0036

Phys /Me Exan

Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

· 2 3		Decedent's Name (First, Middle, Last)					2. Date of Dea		3. Time of Death
Physicia		DIAN M. RIDGE			JUNE 2	6, Day 2007 Ye	10:40 A ^M		
/Medic Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town, or	Location of Death	<u> </u>	4c. County of D	eath
		GENESIS HAMMONDS L	ANE ELDERCARE		BROOKLY	N PARK		ANNE A	RUNDEL
Funeral		Social Security Number 6. Sex	8. Date of Birth (Month, Day	(Year) 9.	Birthplace (State or Foreign Country)				
Director		212-36-4338	M 2XF 66	Yrs.	Months Days	Hours Min.	Month, Day APRIL 8	,1941 MA	RYLÁND
pur *		Usual Residence of Decedent 10a. State 10b. County	10c. Cib	, Town or Lo	cation				10d. Inside City Limits
anyla •ho	5	MARYLAND ANNE ARUN		BURN					1 ☐ Yes 2 No
28a-f	ect	10e. Street and Number	DEL GLER	DOWN	10f. Zip Code	<u> </u>		l 0g. Citizen of What	Country?
with	Funeral Director	2020 NORMAN RD			21060			UNITED ST	:
ns 23	era		2. Was Decedent Ever in U.	S. 13. V		ispanic Origin? (Sp			mencan Indian,
riter	Fun	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 ☑No	1	f Yes, specify Cuba	ın, Mexican, Puerto	Rican, etc.)		/hite, etc.
el', o	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1□Yes 2█ANo	Specify:		Specify: W	HITE
72 ho	Completed	15. Decedent's Education (Specify only highest grade			dent's Usual Occupa	ation during most of work	ring .	16b. Kind of Busine	ss/Industry
ithin	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired	1)		0.55	
ygier ygier tt, Ibr	Co	12		HOMEN	1AKER	-0.14.4.1.1.1	(F)	OWN HOME	
be fill	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		Maiden Sumame)	
ould Mer narke	To	NORMAN C. SHENTON				ANNA WIL			
12 sh h and 7 is n traun		19a. Informant's Name/Relationship (Typ						r, City or Town, Stat	9, <i>Zip</i> Code) 060
1 and Healt em 2 ther		WILLIAM R. RIDGE / 20a. Method of Disposition	are a second and a		sition (Name of	D, GLEN		20c. Location - City	
nt of nt of t: If it		1 Burial 2 □ Cremation 3 □ Re	moval from State	emetery, cren	natory`or other plac EN MEM.P.	JUNE	30,		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	4 ☐ gonation 5 ☐ Other (Specify) 21. Signalure of Fulleral Self to Licensel			. Name and Addres			JLEN BUKN	IE, MARYLAND
Depariment Department		A Malalla	X	KI	RKLEY-RU	DDTCK FUN	ERAL HOL	ME, P.A. BURNIE,	vm 21061
		23a. Part1. Enter the disease, or complic	ations that caused the death						Approximate
Physician		shock, or heart failure. List only one Immediate Cause (Final	cause on each line.						Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a consequ	ience of):					
Examiner			550 10 (01 00 0 0010040	3.130 3.7.					
	ner	Sequentially list conditions, if any leading to immediate	Due to (or as a consequ	ience of):					
cuted	ami	cause. Enter Underlying Cause (Disease or injury that initiated events c.							
e exe	EX	resulting in death) Last	Due to (or as a consequ	ience of):					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	cian/Medical Examiner	d.							
ding p	/Me	IF FEMALE:	c. If yes, outcome of pregna	nev					
atten for us	ian	in the past 12 months?	1 Live birth 2 Fetal	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	Day Year
the d	Physic	1 ∐ Yes 2 AUNo 9	9 Unknown	saii SE					
that	y P	Part II. Other significant conditions cont	ributing to death but not resu	ilting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contribut	e to the cause of death?
w requires that the d been signed by the should be detached	d by	Coophages	i Vaci	ies			1 🗆 Y	es 2 🗆 No 3 🗀	Probably 4 Phknown
s bee	Completed	Chronic	Ronal	Di	sease	_	24a. Was a	n 24b. Were	autopsy findings available
The la	mo				30 p 30		autops	sy prior med2 death	to completion of cause of
an: tifica tor, p	0	25. Was case referred to medical				26. Place of Deat			es 20 No
ysici is cer direc	O B	examiner? 1 Tes 2	espital:	ER/Outpatien	t 3 DOA Oth			ence 6 Other (5	Specify)
ig Ph ter th neral	n: T	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Worl			ow injury occurred	
andir sath. or: Af he fui	atlo	2 Accident investigation	(, 22)			Yes 2 □No			
r Atter de irecte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Since City or Town	treet and Number of n, State)	Rural Route Number,
rs af		<u> </u>							
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Medical Examin	cian: To the best of my kno- er: On the basis of examinat	wledge, death ion and/or inv	occurred at the time vestigation, in my or	ne, date and place, pinion, death occur	and due to the c red at the time, d	ause(s) and manne late and place, and	as stated. due to the cause(s)
thin 2 the mple	Med	one) 29b. Signature and title of ortifier	and manner stated.		29c. License			9d. Date signed (M	
F 3 F 8						~	.	. ((
		30. Name and address of person who con	moleted cause of death (Item		Print)	29465		6126	103
6		Tude Muniera r		F F	>AK wood	4 0001	Caliera	Birnie	MD 21061
Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture		C: FO#10			
Registr		JUN 2 8 200	7 1	A.	all D				
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician F. RAMEY LUKE 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAITIMORE SQUARE 6. Sex 1 1 M 2 □ F Birthplace (State or Foreign Country) Social Security Number vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 80 410-44-1518 6/13/1927 TENNESSEE Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a, State 10h County 10c. City, Town or Location a or 28a-f show the notified at 1 ☐ Yes 2 No MD BALTIMORE WHITE MARSH Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 11433 PULASKI HIGHWAY 21162 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Mary Yes 2 No If Yes, Give Year or Dates: KOREA 1 Never Married 2 Married WHITE 1 ☐ Yes 2 📉 No Specify. Baltimore, Maryland 21215-0036 ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HAULER MOVING VAN UNK. UNK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNK. UNK. UNK. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RONALD W. PARKER / <u>11450 PULASKI HWY WHITE MARSH, MD 21162</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/28/07 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE BALTIMORE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Sepsis 2 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NASIOMOLL Sequentially list conditions, Due to (or as a consequence of) Examiner Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed COLON CANCER Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9∏Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

NOTYES 2□ No 24a. Was an autonsy performed Yes 2 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 [Inpatient Certification: To funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 06-26-200

State Registrar

5

31. Date filed (Month, Day, Year)

JUN 2, 8 2007

S. SIUASALLAM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

602 is Afwood, suite 200, Belair MD 21010 2. Registrar's Signature

Dec.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2007 nne Audrey Marie Ruths /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SWY Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday 6. Sex **Funeral** 1 ☐ M 2X☐ F Director 12/14/1926 217-20-8782 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23e or 28e-f ehow 1 Tyes 2 No Director Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral <u>28 Nicholson Drive</u> 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. of Health and Mental Hygiene. Item 27 is marked other than "naturel", or items other treumatic event, the Madical Examination 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗡 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper/Receptionist Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Andrew Hayne Florence Cunningham ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 28 Nicholson Drive, Pasadena, Carroll L. Ruths/Spouse MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 nent of H ant: If Ite 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or once. Glen Haven Cemetery 6/30/2007 Glen Burnie, MD ' 4 ☐ Donation _5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Stallings Funeral Home, P.A. 23a. Part1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician ear /Medical Due to (or as a consequence of Examiner Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: Box 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 25 No No 1 TYes Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other. 4 Nursing Home 5 Residence 6 Other (Specify) npatient ۵ 1 Yes 2 No 2 ER/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funerel L To the Hospitel tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifiel Medical

State Registrar

title)of certif

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and

KOF

DHMH 17 Rev 1/2001

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32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Amend #6, perFH, 6868, 6/28/07 TT For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death blay Year **Physician** 2007 UB KOSE REDING JUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Yrs. Director 215-14-8309 86 06/13/1921 MD Usual Residence of Decedent 10a. State 10c. City. Town or Location a or 28a-f show t be notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a iner must b 1500 BEDFORD ROAD #104 by Funeral 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian 'natural", or iten dical Examiner Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of health and Mertal Hygiene. Internate 17 is marked other than "natural", or iten any or other traumatte event, the Medical Examiner any or other traumatte event, the Medical Examiner. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No WHITE Baltimore, Maryland 21215-0036 Specify Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOUSEWIFE OWN_HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BENJAMIN SHOCKET ဥ REBECCA LEAH ARRICK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 CHADFORD ROAD - BALTIMORE, MD 21212 ANDREA WEISS / DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MENS permit. Page Department of Important; If any Injury or 06/27/2007 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) DROMARY MRTERY /Medical Due to (or as a consequence of): Examiner HERRY Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed RENM CHRONIC HCHIE Due to (or as a consequence of): burial-tran P.O. Box 68760, physician the buria Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death signed by the at d be detached for 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 🗌 Yes 2No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an s certificate has t irector, page 2 s autopsy performed? 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To nours after death.

neral Director: After this y filled in by the funeral di 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Natural 2 Accident Injury 5 Pending investigation 1 □ Yes 2 □ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral I

completely filled 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Mopth, Day, Year) 29b. Signature and title of certifier 29c. License number mulla m.o June 25 D41410 201 JOGINGER P MEHTA 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) HOS PITAL RANDAUSTOUN 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. 1 - State of Maryland / Department of Health and Mental Hygiene per verb., g868, 06/27/07dhb.

Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Sellors James H. 2007 24 6:00a June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 2120 Troon Overlook Woodstock 8. Date of Birth
June 9, 1928 Birthplace (State or Foreign Country)
 MD 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sev 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1**X**□ M 2□ F 79 MD Yrs 218-22-2566 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show te notified MD 1 ☐ Yes 2 ▼ No Director Howard Woodstock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 must be 23a 2120 Troon Overlook 21163 USA Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☐ No þ Specify: White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Business Businessman is marked other aumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Sellors ၉ Marie Louise Hildebrandt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other traignee. 2120 Troon Overlook Woodstock, MD 21163 Mrs. Margaret Sellors (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crestlawn Mem. Gardens 6/28/2007 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HATCHIO FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that call ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TENTE Sclenosis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Hospital or Attending Physician: The law requires that the death cartificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) ed ed 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 【XNo Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural
2 Accident Injury 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier

X

within 24 hor To the Fune

31. Date filed (Month, Day, State Registrar

(Check only one)

29b. Signature and title of certifier

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32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Twee Frint)

Year)

2007

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- State Amend #17, perFH, G868, 6/28/07 TT Cortificate of Department of Particular of Department of Particular of Department of Particular of Department of Departme 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** PHYLLIS STEVENSON 1:05A JUNE 21 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUMMIT PARK HEALTH & REHABILITATION CENTER CATONSVILLE BALTIMORE 8. Date of Birth (Month, Day, Year) 16 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
S. CAROLINA ge (In vrs. last birthday) **Funeral** 1 □ M 2 ▼ F Months Days Hours 220-05-0507 91 Yrs. CAROLINA (***) Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits MD 1XYes 2 No N/A Director BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 1605 N. MONROE STREET 21217 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify. Specify: BLACK 3 XWidowed 4 ☐ Divorced ear or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BEAUTICIAN COSMETOLOGY 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN-Enoch Samuels ၉ CONNIE SMALLS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHIRLEY EDWARDS / DAUGHTER 5502 WESLEY AVENUE, BALTIMORE, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State ARBUTUS MEM. PARK 6/27/07 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE CO, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Funeral Service Licensee 4600 LIBERTY HEIGHTS AVENUE, BALTIMORE, MD htt. Enter the disease, or complications that caused the dea hock, or hear failure. List only one cause on each line. h. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Yes 2**0**00 Certification: To 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2

State Registrar 31. Date filed (Month, Day,

Year)

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2007 June 23, Year Physician 6:40PM M Sellner Edith Trene /Medical 4c. County of Death 4a. Facifity Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles LaP1ata Civista Medical Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 TF 95 Yrs. Director 578-20-8044 Feb. 8,1912 Marvland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "netural", or Iteme 23a or 28a-f show eny injury or other traumatic event, it a Medical Exercites from the notified at 90nes. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 👿 No White Plains Directo Marvland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20695 9885 Hope Acres Road Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Prince George's Co College (1-4or 5+) Elementary/Secondary (0-12) School System School Bus Aide 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be I. ပ Jessie John C. Day 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9885 Hope Acres Road White Plains, Maryland 20695 June S.Payne (Daughter) Date 28 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 1 ₺ Burial 2 Cremation 3 Removal from State Trinity Memorial Gardens Waldorf, Maryland 2007 4 □ Donation 5 □ Other (Specify) 20735 MD 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral Son 6633 Old Alexandria Ferry Road Clinton, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction 1 week /Medical Due to (or as a consequence of) **Examiner** Atherosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) the attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2√XNo 9 ☐ Unknown been signed by Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Alzheimers Disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Hypertension has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 🖵 Inpatient 3 DOA 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident completely filled in by the within 24 hours after deat To the Funeral Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Nelson V. Benjers, M.D. 9131 Piscataway Road #600 Clinton, Maryland 20735 31. Date filed (Month, Day, Year) Registrar's Signature State

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Registrar

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_	For State Registrer	State of Mary				d Mental Hyg	1 1 W W	28030		
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	321 N. Johnatha	n Street #B		Hagers	town		Washing	ton		
	217-42-7714	*u o 🗆 r		Months Days		Ain. (Month, Day,	1944	rthplace (State or Foreign Country) unk		
Jor	10a. State 10b. County 10c. City, Town or Location									
Direc	10e, Street and Number 321 N. Johnathan	Street #B		10f. Zip Code	21742	1	0g. Citizen of What C	Country?		
2	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	į		dispanic Origin? an, Mexican, Pi Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Am Black, Wh Specify: b	ite, etc.		
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2	Thelma Walters/fr	iend 20	321 N	Johnat	han Str	eet #B Hay	erstown,	Mi) 21742		
	21. Signature of Funeral Service licen	la state	or S	. Name and Addre	ss of Facility	ard,655 W.	Baltimore	e Street		
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Me	29b. Signature and title of certifier	and manner stated.	(Item 23a) (Type,	ND 29c. Licens						
	Completed by Fulsical International Examined	Allen Swan 4a. Facility Name (If not institution, give 321 N. Johnathan 5. Social Security Number 6. Se 217–42–7714 Usual Residence of Decedent 10a. State 10b. County MD Washington 321 N. Johnathan 1. Marital Status 10b. County MD Washington 321 N. Johnathan 1. Marital Status 10b. County MD Washington 30b Middle 4 MDivorced 15. Decedent's Education (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify only highest grade (Specify) only highest grade (Specify) (Specify) 15. Decedent's Education 30b Marital Marital Status 10b Marital 9 Marita	1. Decedent's Name (First, Middle, Last) Allen Swan 4a. Facility Name (If not institution, give street and number) 321 N. Johnathan Street #B 5. Social Security Number 217-42-7714 1	Registrer Color	Decedent's Name (First, Middle, Last) Allen Swan	Decedent's Name (First, Middle, Last)	Decident's Name (First, Microte, Last) 2 Date of Death Allen Swan 2 Date of Death Allen Swan 4.5 Reptor Name (First, Microte), Date of Allen Swan 4.5 Reptor Name (First, Microte), Date of Death 4.5 City, Town or Location of Death 4.5 City, Town or Location of Death 4.5 City, Town or Location of Death 4.5 City, Town or Location 4.5 Date of Security Number 5.5 Death 5.5 Dea	Decident's Name (Pint, Medies Lists) 2 Date of Death Reg. No. 1		

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		4	1. Decedent's Name (First, Middle, Last)						Date of Death Month	h Dav	Year	3. Time of Death	
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	Funeral		1⊠M 2□F	s. last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day,			place (State or Foreign intry)	
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	yland		10a. State 10b. County 10c. 0	City, Town or L	ocalion							10d. Inside City Limits	
	a-fe	ctor	MD Prince George's C	ollege	Park							1 ☐ Yes 2 No	
	or 28	Director	10e. Street and Number		10f. Zip	Code	207/0	`	10	0g. Citizen o		intry?	
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Maryland 21215-0036	m = 0 =	Be	17. Father's Name (First, Middle, Last) Michael John Sassano				Lill:		o (First, Middle, ∧ Ra1oh	walden Suma	ime)		
<u> </u>	d Mental I	P	19a. Informant's Name/Relationship (Type, Print)	19h Mail	ing Address	(Street			il Route Number	City or Tow	n State 7i	n Code)	
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آ ا	Pages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)	cemetery, cre	matory or o	mer plac	(B)						
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked eny injury or other traumatic es 90cs.		21. Signature of Faneral Straiges Lensee Wade, Directo		State Baltin		•		d 655 W.	Balt	imore	Street	
			Sa. Party. Enter the disease or complications that caused the deshock, or heart failure. List only one cause on each line.							əst,		Approximate Interval Between	
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Вох	eath certific attending p I for use as I	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ F		□Ectopic pr	ecnancy	,				ate of deliv		
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Division of Vital	or Attending ufter death. Director: After in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - A building, etc. (Spe	t home, farm, s ecify)					28f. Location (Si City or Town		nber or Ru	rai Route Number,	
_	Hospital 4 hours a Funeral I	Medical Ce	29a. Certifier (Check only one) Certifying Physician: To the best of my life (Check only one)										
	To the within 2 To the complet	Me	29b. Signature and type of certifier		290	. Licens	e number		2	9d. Date sig	ned (Month	n, Dey, Year)	
	H > H 0		1-12 - 6002.1	110	D	00	064	98	3	1/2	1/-		
			30. Name and address of person who completed cause of death (I	tem 23a) (Type	e, Print)		U	10		010	147		
			Kashif Alam Firozvi. MD Washington	Adventist	Hospit	tal	Takoma	Park	MD				
Phys.	Sta Regist	ate	31. Date filed (Month, Day, Year)	gnature	wh)				.,				
100	negist	1-1	JUNIZ O COUL PROPERTY &	- July									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** TEWELES SIDNEY 1 .20 A M June 26 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Dec 22, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F 395-01-4604 1914 Wisconsin Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 📆 No Director Fairfax McLean Virginia 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 22102 7811 Birnam Wood Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) U.S. Weather Bureau Meteorologist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Regina Schultz Sidney Teweles Sr. ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8908 Bent Brook Drive Garden Ridge, TX 78266-2002 Robert B. Teweles, Sr., Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 06/28/07 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee

Inomas Gregory 22. Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cholanaitis Physician WECK /Medical Due to (or as a consequence of): **Examiner** Pancreatic cancer 6 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 hor To the Fune completely f the 29b. Signatune and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

12

Registrar

SHIYAMA MUDALI, JOHNS HOPKINS HOSPITAL, 600 N. WOLFE ST. BALTIMORE
31. Date filed (Month, Day, Year) | 32. Figistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mudel, Medical Dator

RES-000

June 26, 2007

ORIGINAL

DHMH 17 Rev 1/2001

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Ralph Charles Thomas, Jr. June 26,2007 7:20AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital C<u>heverly</u> Prince George's If Under 1 Year | If Under 24 Hrs. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 M 2 □ F Yrs 216-14-6654 84 July 31,1922 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 10708 Hollaway Drive 20772 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 15 Yes 2 No 1943 — If Yes, Give Year or Dates: 1945 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify.African 1 ☐ Yes 2 ☐ No Specify 2 3 ☐ Widowed 4 ☐ Divorced American
16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Biology Tech Supervisor 12th FDA Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ralph C. Thomas, Sr. ဂ္ Marie Barnes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra Dorothy Thomas_(Wife) 10708 Hollaway Drive Upper Marlboro, MD 2077
of Disposition (Name of Date 20c. Location - City or Town, State _MD_20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State July 2, 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. Cheltenham, Maryland 2007 21. Signature of Faneral Septical 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Septic Shock /Medical Due to (or as a consequence of) Examiner Urosepsis
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Thrombocytopenia

Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical Multiple Skin Ulcers attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performe 1∐ Yes 2 3 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2☐ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation (Month, Day Year) 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 CxCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Eur D 0057636 June 26, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Eben, M.D3001 Hospital Drive Cheverly, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 2 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

07-04429 Ja

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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edical Examine	er		Uko ,	James Oku			4b. City, Tow	orloca	ation of [Death:	Month Une 9, 2	007 4c	. County of	Death	
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	5	Social Security Number		_	Age (In yrs. Ia	st birthday)	If Under 1	Year If	f Under 2		. Date of B	irth (MM/	DD/YYYY)	9. Birth Foreign	place (State or
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21215-0036 und be filed within 7 Mental Hygiene. marked other than ic event, the Medica		Okorie 19a. Informant's Name	Gabr			19b. Mail	ing Address	(Street a	ind Numb	per or Ru	ral Route N	lumber,	City or Tow	n, State	, Zip Code)
	-1	Emmanuel		/Friend		1130	1 Narro	ow Tr	rail	Ter	race	Belt	svill	e, 1	MD 20703
Baltimore, MD Department of Health and Department of Health and Important: If item 27 is	- 1	20a Mathad of Dispo	sition		20b.	Place of Disp crematory or	osition (Name	of ceme	tery,		Date	- 1			Town, State
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taminer		Immediate Cause (Final disease or condition resulting in death) a. Cardiomegaly with left ventricular hypertrophy and right Due to (or as a consequence of): ventricular dilatation													
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that it is after death. "al Director After this certificate has been signed by all or the funeral director, page 2 should be detact	Certification:	2 Accident	lnv	estigation 28e, Plac	e of Injury - A	t home, farm,	street, factory	, office b	uilding,	etc.	28f. Loca	tion (Stre	eet and Nur	nber or	Rural Route Numi
Divisic To the Hospital or Attet within 24 hours after des To the Funeral Directo completely filled in by th	E	3 Suicide	det	termined (Specify)											
Lospite Hour uners		4 Homicide 29a. Certifier	Certifying	Physician: To the be	st of my know	rledge, death	occurred at the	e time, da	ate and p	olace, and	d due to the	cause(s) and man	ner as s	tated.
the H hin 24 the F	Medical	(Check only one) 2	Medical Ex	Physician: To the be caminer:On the basis and manner:	of examination	on and/or inve	stigation, in m	y opinion	i, Ceaii C	JCCUITCU	at the time,			_	
To To	ĕ	29b. Signature and	title of certi				29	c. Licens		er		- 1			Month, Day, Year)
	1	(A)	10 To	> '				O.C.	M.E.				June 10,	2007	
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olped		Ana Rubio		ssistant Medical			nn Street,	Daitimo	ore, M						
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	Dhi-i		1. Decedent's Name (First, Middle,	Last)					2. Date of D	Death Day	Year	3. Time of Death
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1	Funeral Director		212-01-1458	6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. 95	• • • • • • • • • • • • • • • • • • • •	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of B (Month, D Jan 16	5, 191	9. Birth Cou Mary	nplace (State or Foreign untry) Yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town or Lo	cation					10d. Inside City Limits
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Baltimore,	S to I		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other (Sp	ecify)	State	cemetery, crer	sition (Name of natory or other pla	сө)	Date	20c. Loc	cation - City or I	own, State
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			23a. Parl 1. Enter the disease, or of shock, or heart failure. List of	complications that only one cause on e	caused the dear	th. Do not ent	er the mode of dyli	ng, such as o	cardiac or respiratory	arrest,		Approximate Interval Between
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8760,	cate be executed physicien and the burial-transit	dical		d								
.O. Box 6	death certifi e attending id for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 19 No 9 ☐ Unknown	1☐Live b 4☐Pregr	3c. If yes, outcome of pregnancy 1					2	3d. Date of delik Month	very Day Year
۵.	The law requires that the tte hes been signed by th page 2 should be detache	þ	Part II. Other significant condition	s contributing to d	eath but not res	sulting in the ur	nderlying cause giv	ren in Part I.		tobacco us		the cause of death?
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6	Physicien: r this certific ral director,	2	1 ☐ Yes 2 No 27. Mann of Death	-		ER/Outpatien		4	sing Home 5 Res			nfy)
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Division	l or Attending after death. Director: After I in by the fune	Certification:	2 Accident investigated a Could not determine a communication and	ot be 28e. Place	of Injury - At h		eet, factory, office	163 2 014	28f. Location	(Street and	Number or Rui	al Route Number,
۵	To the Hospitel or Attending Physicien: within 24 hours alter death. To the Funeral Director Affer this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying	Physician: To the	best of my kno	owledge, death	occurred at the ti	me date and	place, and due to the	a cause(s)	and manner as	stated
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical	one) Medical E	Kanimier: On the bi	asis of examina ner stated.	ation and/or inv	estigation, in my o	pinion, death	occurred at the time	, date and	place, and due	to the cause(s)
	Wit Co	=	29b. Signature and title of certifier	Cu			29c. Licens	1908	6		signed (Month 7/2007	, vay, Year)
			30. Name and address of persons	ho completed caus	e of death (Iter		Print)		AVET	L 11	MO	21217
	Sta	te	31. Date filed (Month, Day, Year)	32. R	egistrar's Signa			ر حرود	- mar t	~ 14	- س	<u></u>
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Waldorf Roy

07-04821

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robert Wilson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day June 25, 2007 Son 0943 hrs Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death University of Maryland Baltimore Ň If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Months Hours Director Country) NC 246-76-0016 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 : Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 2 Funeral 11. Marital Status Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Fri Can Yes f Yes, Give Year Yes 2 No specify: American Widowed 4 Divorced þ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done within 72 hours 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than ' Baltimore, MD 21215-0036 Trucking 04 Pages 1 and 2 should be filed withinent of Health and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be UNK UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other traumatic Baltimore MD Br unt Eloise 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation Removal from State 0 Say view Crematon Donation 5 Other Specify: 22. Name and Address of Fallity 21. Signature of Funeral Service License Fineral Senvice, PA 105e Hani 512 Belan Road, Baltman MD 21206 Approximate in erval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Aortic dissection Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Hypertensive cardiovascular disease Sequentially list conditions, Due to for as a consequence off: if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last attending physician and or use as the burial - transit The law requires that the death certificate be executed Physician/Medical X UNPENDED A#5955, PII, 27, perME, g869, 7/5/07 TI Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the a detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 ✔ Unknown Cocaine use Completed has been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✓ Yes 2 1 V Yes the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Other 4 examiner? Hospital: 1 DOA Inpatient 2 FR/Outpatient 3 Nursing Home 5 Residence 6 1 ✔ Yes ٩ No After 27. Manner of Death 28a. Date of Injury (Month, Dey, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending 24 hours after death, To the Fineral Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 26, 2007 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

egistrar's Signatur

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Marylar		rtment of He tificate of D			giene 200	7 20000
	Physici /Medic		Decedent's Name (First, Middle, Last) William		\	Nright	+	2. Date of Dea Month		3. Time of Death 94:36 A M
)	Examin		4a. Facility Name (If not institution, give s て H E フ O H M S H O F M I M			4b. City, Town, or BALT IM			4c. County of	Death
	Funeral Director		214-266233	7. Age (In yrs. 55	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day /2, /2,	r, Year)	Birthplace (State or Foreign County) ary and
	nyland how		Usual Residence of Decedent 10a. State 10b. County		y, Town or Loc					10d. Inside City Limits
	he Ma	Funeral Director	Maryland 10e. Street and Number	Ba	altimo	10f. Zip Code			10g. Citizen of Wha	1 XYes 2 □ No
	3a or	i Dir	1420 North Colling to	n Avanua		21213			u.s.A	•
	me 2	nera		Was Decedent Ever in U Armed Forces?	.S. 13. W	as Decedent of His Yes, specify Cubar	spanic Origin? (S	pecify Yes or No	14. Race -	American Indian, White, etc.
5-0036	filed within 72 hours after death with the Maryland Hygiene. yther then "natural", or lleme 23a or 28a-f ehow int, the Madical Examiner must be natified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		□Yes 2 X No	Specify:	, , , , , ,	Specify:	Black
2	"natu	letec	15. Decedent's Educ (Specify only highest grade		16a. Decede	ent's Usual Occupa ind of work done do O NOT use retired)	tion uring most of wor	king	16b. Kind of Busin	ess/Industry
2121	filed within Hygiene. other then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		abover			Home In	provement
Maryland	d a b	To Be (17. Father's Name (First, Middle, Last) William D	redden					Malden Sumame) Wrigh	t
Mary	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 le marke eny injury or other traumatic.	1. (3	19a. Informant's Name/Relationship (Type Teenie Murray)	Sister		ast 28 th			r, City or Town, Sta	
	t Healt Hem 2:		20a. Method of Disposition	20b. F		QSI & 0 ition (Name of atory or other place		Date	20c. Location - Cit	
Ē	Pages nent of ant: If it ury or o		t Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)					- 2007 1	Lansdow	ne, Maryland res F/H, P.A.
Baltimore,	permit. Departm Importal eny inju		21. Signature of Funeral Service License		22.	Name and Address	s of Facility	e Derri	ck C. Jor	es F/H, P.A.
	40360		23a. Part1. Enter the disease, or complic	cations that caused the deat						, Maryland 21215
7	Physician /Medical	·	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	Le s	EPS15				Interval Between Onset and Death
I	Examiner			PNEUMUA						1 WEEK
	sit sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of).					
90	icate be executed physicien and s the burial-transit	il Examiner	that initiated events cresulting in death) Last	Due to (or as a conseq	uence of):					
68760	ficate t physics ts the t	edicai	d						1	
Box	death certiff e ettending id for use as	an/M	23b. was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			23d. Date o	,
о. В	at the death certific by the ettending parached for use as	Physician/Me	in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	4☐ Pregnant at time of d 9☐ Unknown		Other (specify)			Month	Day Year
٥.	es that igned by be deta	by Ph	Part II. Other significant conditions con			derlying cause give	n in Part I.		~ /	ite to the cause of death?
org	w require been sig should b	ted	END STAGE	LIVER DI	SEASE			1 🗆 Y	es 2.021Nulo 3[Probably 4 Unknown
Vital Records,	e fa has je 2	Completed							med dea	re autopsy findings available r to completion of cause of th? Yes 2 \(\sum \) No
/ita	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	anital S. d		100		th (Check only or	ne)	
Division of	ng Phys fter this ineral dii	lon: To	27. Manner of Death 1 ■ Natural 5 □ Pending	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	4 Nursing H		ence 6 Other (ow injury occurred	(Specify)
Vision	l or Attendi after death. Director: A In by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, tarm, stre		3 2	28f. Location (S City or Tow	ireet and Number (or Rural Route Number,
۵	To the Hospital or Attent within 24 hours after deatl To the Funeret Director: completely filled in by the		29a. Certifier 12 Certifying Phys	ician: To the best of my kno			e, date and place			er as stated.
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Examin	er: On the basis of examina and manner stated.	ition and/or inve	estigation, in my op	inion, death occu	rred at the time, o	date and place, and	due to the cause(s)
)	To T To 1	2	29b. Signature and title of certifier			29c. License			29d. Date signed (A	
*	j		30. Name and address of person who co				RES-DI	00	June 2	7/2007
_			MAUDIA TAUSER.	Loins Hope	ns Hos	•	NO NORAL	WOLFE S	IRECT, BAT	MUNE HIMYUTOD
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registrar's Signa	g. for	we will				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Otate of Marylar	•	rtificate of		,	Reg. No.	
	Physici	ian	1. Decedent's Name (First, Middle, Las	st)				2. Date of Dea Month	Day Year	3. Time of Death
	/Medi		Lenel Whaley					June 9	, 2007	10:00 PM
	Examir	ner	4a. Facility Name (If not institution, give				r Location of Death	1	4c. County of Dea	
_	Funeral	_	St. Thomas More 5. Social Security Number 6. S		last birthday	Hyatts	If Under 24 Hrs.	8. Date of Birth	Prince G	eorge's thplace (State or Foreign
	Director			□M 2∏F 54		Months Days	Hours Min.	July 14	, 1952 Pen	ountry)
	yland yland at		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	e Mar a-fsh tiffed	cto	MD Prince	George's H	lyattsv	ville				1 □Yes 2√No
	n with the 3a or 28 st be no	al Director	10e. Street and Number 4922 LaSalle Road			10f. Zip Code	20781		10g. Citizen of What C USA	ountry?
	deatl	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cubi	lispanic Origin? (Span Mexican Puert	pecify Yes or No-	14. Race - Ame	
2-0030	urs after al', or Ite Examine	þ	1 □ Never Married 2 □ Married 3 □ Widowed 4 🎇 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:	o nican, etc.)		olack
ה ה	72 ho natur ilcal	Completed	15. Decedent's Ed (Specify only highest gra	fucation	16a. Dece	dent's Usual Occup	ation during most of wor	kina I	16b. Kind of Business	/Industry
V	ithin ne. han "	늍	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done DO NOT use retired		n///g	1	4 - 1
7	iled w Hygie ther ti	S	12 17. Father's Name (First, Middle, Last)	<u>Z</u>		unit seci		o (First Middle	hospi Maiden Surname)	taı
yland	Mental Harked of	To Be	Arlene Whaley				Emily T	aylor		
, Mar	and 2 sho salth and 27 Is ma er trauma		19a. Informant's Name/Relationship (Keia Straughter/		19b. Maili 5739	ng Address (Street) A Summe:	and Number or Ru r Street	ral Route Numbe Ph iladel	r, City or Town, State, Lphia, PA	^{Zip Code)} 19139
Dalthillore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☑ Other (Specifi	Removal from State	Place of Dispo cemetery, cre	osition (Name of matory or other plac	ce)	Date	20c. Location - City or	Town, State
Dall	permit. Departr Importa any Inji		21. Signature of Funeral Senice ficer ROnald S	wade, Directo		2.Name and Addre tate Anat altimore,			Baltimore	Street
1	14.4	Г	Zia. Park. Enter the direase or or m shock or heart failure. List only	tions that caused the deat					rest,	Approximate Interval Between
	Physician		Immediate Cause (Final	Royal Fo	11/4	-8				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):					00-22-
	Examine	,	Sequentially list conditions,	b. Due to (or as a conseq						
	ted nsit	ië.	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to for as a conseq	juence or).				-	
,	execunate and al-tra	Examiner	that initiated events resulting in death) Last	CDue to (or as a conseq	uence of):					
00/00	rificate be executed ig physician and as the burial-transit			d						
Š	ertifica ling ph e as t	Med	IF FEMALE:							_
0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf pregnation 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of continuous good Unknown	al death 3	⊒Ectopic pregnancy ⊒ Other (specify) _	/		23d. Date of de Month	livery Day Year
Ţ	that ined by detay		Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
colds,	requires sen sigr tould be	ted by	Kespiratory -	pailure/	Live	r fai	lure	1 🗆 Y	es 2 No 3 P	robably 4 Unknown
ב ב	The law te has b age 2 sh	Completed	Encephalopa	Thy/cer	ngest	al Inta	ration	24a. Was a autops perfor	sy prior to med? death?	utopsy findings available completion of cause of
0	ian: rtifica stor, p	Be C	25. Was case referred to medical	911154 60	regevi	<i>//</i> (// -/ -/ -/ -/ -/ -/ -/ -/ -/ -/ -/ -/	26. Place of Dea	th (Check only or	2 ☑ No 1 ☐ Yes	s 2□No
>	hyslc his ce I direc	To E	examiner? 1 ☐ Yes 2 █ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing H	ome 5 Resid	ence 6 Other (Spe	ecify)
5	nding Pl th. r: After ti e funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	yat k? Yes 2 ∐No	28d. Describe he	ow injury occurred	
	al or Atte s after des al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Special	ome, farm, sti	reet, factory, office		28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
	ne Hospit n 24 hour ne Funera	Medical C	29a. Certifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the tin exestigation, in my o	me, date and place opinion, death occu	, and due to the c rred at the time, c	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	- 12 2	011	29c. Licens	e number	2	29d. Date signed (Mon	th, Day, Year)
			Mulle	anleur	e sik	\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \	01852		JUNG 10	2007
			30. Name and address of parson who	completed cause of death (Iter	n 23a) (Type,	Print)	um Rd	Huch	tsville N	18 20181
	Sta Registr		31. Date filed (Month, Day, Year) JUN 2, 8, 2	32 Registrar's Signa	ature	rester			-	1h, Day, Year) 2007 18 20781

DHMH 17 Rev 1/2001

			For	State of M							-		_	e.		
			1 - State Registrar			Ce	ertificat	te of	Death			Reg. No.	200	17	209	05
т	Physici	an	1. Decedent's Name (First, Middle, L							1	Date of Demonstrate	eath Day		ear	3. Time of De	
-	/Medic		Catherine Marie V								Month Day Year 11:30A M					
-	Examin	er	4a. Facility Name (If not institution, g			4b. City, Town, or Location of Death							County of		,	
	Funcion		Baltimore Washing 5. Social Security Number 6.			nter last birthda	Glen V) If Unde		11e If Under 2	24 Hrs.	8. Date of Bi	rth	ne Ar			oreian
	Funeral Director		579-36-5988	1□M 2√F	82	Yrs.	Months		Hours	Min.	(Month, D 37/26/	ay, Year)	'	Coun	ace (State or Fi try) MD	or orgin
	D		Usual Residence of Decedent		T						01/20/					
	arylar show d at	F	10a. State 10b. County MD Anne Art	n dol	Oden	y, Town or I	Location							11	od. Inside City L 1 ☐ Yes 2	
	he M 28a-f otifie	Director	MD Anne An	midei	den	COH	101 7	- Code				10a Citi	zen of Wha	at Cour		A
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. I and Mental Hygiene, is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	al Dir	2256 Canteen Circ	cle			10f. Zij 211					Tog. Citi		SA	uy:	
	deatl	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13	B. Was Dece	dent of F	lispanic Orig an, Mexican,	jin? (Spec	cify Yes or N	0-	14. Race -	Americ White,		
9	after or ite	/ Fu	1 Never Married 2 Married	1 ☐ Yes 2 ☐ If Yes, Give	No		1 ☐ Yes		Specify:	, ruento r	iicaii, etc.)					
Ö	hours ural",	d by	3 Widowed 4 Divorced	Year or Dates:		10- D		7.				401.16	Specify:			
7	n 72 "nat edica	Completed	15. Decedent's (Specify only highest g	rade completed)		(Giv	edent's Usu ve kind of wo . DO NOT u	ork done	during most	of workin	g	16b. Ki	ind of Busir	iess/ind	lustry	
72	withi	omp	Elementary/Secondary (0-12)	College (1-4or	5+)		ekeepe		,			liniv	ersit	v of	Maryla	hae
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/lar	should be and Mental smarked o	To E	Eugene L. Thomas			_			Nelli	e Bro	own					
lan	ss 1 and 2 should of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship	(Type. Print)			_		and Number					ate, Zip	Code)	
ა ბ	1 and Health em 27 ther tr		Connie Proctor		20h E				Circle		enton,			T.	Diete	
>			20a. Method of Disposition 1 → Burial 2 □ Cremation 3	☐Removal from State			position (Na rematory or						ocation - Cit		wn, State	
블	permit. Page Department Important: Il any injury o		4 Donation 5 Other (Special Signature of Saneral Service Let		lyid.		d Nati		ess of Facility		/2007	Laure	er, M	D		-
Ba	Department and and and and and and and and and and		11/1/			S	Gary I	. Ka	aufman ngton	Fune	eral H	ome a	at MM	P,]	NC.	
p.C.Ma	34.31		23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that caused	the deat	h. Do not e	nter the mo	de of dyir	ng, such as o	cardiac or	respiratory	arrest,	الا معال		Approximate Interval Between	en
	hysician		Immediate Cause (Final disease or condition	Ca Aa	. 4										Onset and Dea	ath
Total S	/Medical		resulting in death)	a. Due to (or as	a conseq	uence of):										
	Examiner		Sequentially list conditions.	b												
0	sit ed	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):										
S.	be executed cian and ourial-transit	xan	that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of):								_		
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687	tificate g phy as the	ledic		-u.							-					
Box	th cert	M/ue	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			B⊟Ectopic p	reananc	v				23d. Date o			
E	ed for	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a 9□Unknown			Other (s		,				Month	1	Day Yea	ar
<u>Р</u>	ires that the de signed by the a I be detached f	Phy	9 ☐ Unknown Part II. Other significant complitions		ut not roc	ulting in the	underhing	nouse air	on in Bart I		230 Did	tobacca	ica contribi	ito to th	e cause of dea	+h2
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<u>re</u>	in: T ificate or, pa		25. Was case referred to medical	T					26 Place	of Dooth	1 Yes (Check only	-/-	1	Yes	21 50 No	
<u></u>	hysiclan: The Is his certificate ha I director, page 2	To Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpati	ent 2	ER/Outpati	ent 3 De	OA Oth	or.		ne 5□Res		6 ∏Other	(Specifi	·)	
<u></u>	ding Phys n. After this funeral di		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry ıv Year)	28b. Time Injury		28c. Injui Wor			8d. Describe				<u> </u>	
0	endir ath. or: Af he fur	atio	2 Accident investigati	on	, ,	,,	М		Yes 2□N	40						
Division or	or Att fler de Direct n by t	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine				street, factor	ry, office		2		(Street an own, State		or <i>Rur</i> a	l Route Numbe	ır,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, p		29a. Certifier 1 Certifying	Physician: To the best	of my knr	owledge de	ath occurrer	i at the ti	me, date and	d place 3	nd due to the	e cause/e) and mann	er as s	ated.	
	e Hos 24 hc Fun etely	Medical	(Check only 2 Medical Ex	aminer: On the basis of	of examina	ation and/or	investigatio	n, în my	opinion, deal	th occurre	ed at the time	e, date and	d place, and	d due to	the cause(s)	
	To the Hospita within 24 hours To the Funeral completely filled	Me	29b. Signature and title of certifier	1			29	c. Licens	se number			29d. Da	te signed (Month,	Day, Year)	
			> 1 /	/				1150	8423	5		6/	24/	07		
	3		30. Name and address of person wh	o completed cause of o	death (Iter	n 23a) (Type	e, Print)	. /	,	/3	~1	1				
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DHMH 17 Rev 1/2001

*		Examir
		uneral irector
0	after death with the Maryland	or items 23a or 28a-f show niner must be notified at

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after

Division or Vital Records, P.O. Box 68760,

		Decedent's Name	e (First, Middle, La	St)					Date of D Month	eath	Voar	3. Time of Death	
Physicia /Medic		HARRY	WEED	WIS	NER				JÜNE	26	200 ⁷	7:30 p	M
Examin	100	4a. Facility Name (If	not institution, giv	e street and number)		4b. Cit	y, Town, or	r Location of De	eath	4c.	County of Death		
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Funeral		5. Social Security N		ex 7. Ag	e (In yrs. last birt	Month	er 1 Year s Days	If Under 24 H Hours M	Irs. 8. Date of B	irth ay, Year)	9. Birthp	place (State or Foreigntry)	gn
Director			6920	A W Z	79	Yrs.			in. (Month, E 3 / 0 2	/192	8 MARY	LAND	
»		Usual Residence of 10a. State	10b. County		10c. City, Town	or Location					1	0d. Inside City Limit	ts
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28a- notif	Director	10e. Street and Nur					Zip Code			10g. Cit	izen of What Cour	ntry?	
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ms 2	Funeral	11. Marital Status		12. Was Decedent					(Specify Yes or Nuerto Rican, etc.)	0-	14. Race - Americ	can Indian,	
or ite		1 Never Marri	ed 2 Married	Armed Forces? 1 XYes 2 1 If Yes, Give Year or Dates:	No		2 No	an, mexican, Pu Specify:	јепо нісап, етс.)		Black, White,	etc.	
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than re Me	mp	Elementary/Seco	ndary (0-12)	College (1-4or 5	5+)	life. DO NOT		″ JTURIST	TI	DAT	TO. CIT	١V	
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mark mati	ဥ	19a. Informant's Na	ame/Relationship /	Type, Print)	19b.	Mailing Addre	ss (Street	and Number or	Rural Route Num	ber. City o	or Town. State. Zin	Code)	
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f Healitem		20a. Method of Disp	osition			Disposition (A y, crematory o		20)	Date	20c. Lo	ocation - City or To	own, State	
nt: If			Cremation 3 ☐ 5 ☐ Other (Specif	Removal from State	METRO				28/07	BAL	TIMORE,	MD	
Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu		j		22. Name	and Addre	ss of Facility (CVACH/R			ERAL HO	ME
Depai Impoi any Ir		• ($\sim X$			1211		SACO A			ORE, ME		
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Medical		resulting in death)		Due to (or as	a consequence of	of):		•	11/1/		0		
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sit	Examiner	Sequentially list con if any, leading to im- cause. Enter Unde Cause (Disease or	riying	Due to (or as	a consequence of)i):					1		
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nding use a	N.			u.		^ //4	EUI	-10/4/					
atte d for i	<u>~</u>	IF FEMALE:	t pregnant	23c. If yes, outcome	pf pregnancy						23d. Date of delive	3rv	
9 8		23b. Was decedent in the past 12	months?	1 ☐Live birth			pregnancy				23d. Date of delive	ery Day Year	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene 2000 7

		1 - State Registrar	ertificate of Death	Reg.	No.					
Physicia /Medica	2	1. Decedent's Name (First, Middle, Last) Philip Weinstin		2. Date of Death Month	Day Year 7 7:34					
Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	T	4c. County of Death					
and a social contract.		SINAI HOSPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	BALTIMO If Under 1 Year If Under 24 Hrs.	RE Data of Birth	N/A					
Funeral Director		5. Social Security Number 5777-03-1544 6. Sex 1 \square M 2 \square F 93 Yrs	Months Days Hours Min	8. Date of Birth (Month, Day, Ye 09/11/191	9. Birthplace (State or Forei Country) MD					
Maryland -f show lied at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or MD BALTIMORE BALTIMORE			10d. Inside City Limi 1 □ Yes 2 ☑ N					
r 28a	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?					
th wit	a	7203 ROCKLAND HILL DRIVE #306	21209		U.S.A.					
urs arige.	by Funeral I	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 □ No It Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 No Specify: 	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE					
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injur or other traumatic event, the Medical Exa	Completed	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ive kind of work done during most of wor e. DO NOT use retired)	king 16t	o. Kind of Business/Industry					
ed wi ygien ner th			OWNER	(=:	SCRAP YARD					
ild be til lental H rked oth ic even	To Be	17. Father's Name (<i>First, Middle, Last</i>) ABRAHAM WEINST		ne (First, Middle, Mai	den Surname) LEVIN					
shou and M s mar tumat	-	19a. Informant's Name/Relationship (Type. Print) 19b. M	ailing Address (Street and Number or Ru	ral Route Number, Ci	ity or Town, State, Zip Code)					
s 1 and 2 f Health a item 27 is		20a. Method of Disposition 20b. Place of Di	ROCKLAND HILL DRI sposition (Name of crematory or other place)		BALTIMORE, MD 2120 c. Location - City or Town, State					
rtment of h		1 M Burial 2 □ Cremation 3 □ Hemoval from State 4 □ Donation 5 □ Other (Specify)	ISRAEL CONG. 06/2	•	ALTIMORE, MD					
Depar Import any ir		21. Signature of Funeral Service Licensee Mc4 Lec			SON & BROS., INC. PIKESVILLE, MD 2120					
Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)		or respiratory arrest,	Approximate Interval Between Onset and Death					
/Medical Examiner	edical Examiner	Due to (or as a consequence of): Sequentially list conditions b. Ca SEMCech								
		Sequentially list conditions, if any, loading to himborate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Lue to (or as a consequence of): c. Due to (or as a consequence of):								
tificate be ey go by sician as the buria		d								
The law requires that the death certain the the stending the has been signed by the attending age 2 should be detached for use	Physician/IV		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year					
quires that a signed by ald be deta	2	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?					
sician: The law re secrificate has bee lirector, page 2 sho	Completed			24a. Was an autopsy performed						
	Be	25. Was case referred to medical examiner?	26. Place of Dea	th (Check only one)						
ا قِقِ ا	2	1	e of 28c. Injury at	ome 5 ☐ Residence 28d. Describe how i	e 6 Other (Specify) injury occurred					
To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	2 ☐ Accident investigation 3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)		28f. Location (Stree City or Town, S	t and Number or Rural Route Number, itate)					
e Hospi 24 hour e Funera letely fills	Medical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o and manner stated.	r investigation, in my opinion, death occu-	irred at the time, date	and place, and due to the cause(s)					
Vithin To th comp	₩	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)					
		Julin	0000470	,	6/23/07					
10		30. Name and address of person who completed cause of death (Item 23a) (Ty) S.I.H. MALINUM MA 270	29c. License number 0000470 De, Print) O Quary lake I	Vive 2	21209					
Stat Registra		31. Date filed (Month, Day, Year) 32 Registrar's Signature	parle							

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death [□]2007 **Physician** James Edward Yeager, Sr. 25, Jun. /Medical 6:004a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1515 Marsha Road Baltimore Arbutus If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F Months Days Hours Min. 78 Director 219-22**-**2672 26, 1928 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show other tranmatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐Yes 2 ☐ No MD Directo Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1515 Marsha Road 21227 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1√7 Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2√ Married 2 🗌 No 1 ☐ Yes 2√2 No Specify: Š Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Highway Design State Highway Admin. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Herman W. Yeager Ellen Haupt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Yeager - Wife 1515 Marsha Road, Arbutus, MD 21227 Pages 1 a nent of Hea nt: If Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 ☐Removal from State permit. Page Department of Important: If any injury or 06-29-07 Loudon Park Cemetery Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) laco Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed Be

Physician /Medical **Examiner** The law requires that the death certificate be executed

Baltimore, Maryland 21215-0036

2 Certification:

certificate

To the Hospital or Attending Physician;

Division or Vital Records, P.O. Box 68760,

23e. Did tobacco us	se con	ilibute to t	ne caus	se oi dea	itii:
1 □ Yes 2 0	(No	3 ☐ Prof	bably	4 □Un	knowr
24a. Was an autopsy performed? 1∐ Yes 2 No	24b.	Were auto prior to co death? 1 ☐ Yes	-		ailable se of
Check only one)					

						I TOO EMPIN	7					
25. Was case referred to me examiner?	nedical		26. Place of Death (Check only one)									
1 ☐ Yes 2 No		Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpatient 3	DO	A Other: 4 ☐ Nursing H	ome 5 Residence	6 □Other (Specify)					
2 Accident	Pending nvestigation	1	, , ,	28 M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ry occurred					
	Could not be determined		at home, farm, street, ecify)	factory,	, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, e)					
29a. Certifier 12 Ce	ertifying Phy	ysiclan: To the best of my	knowledge, death occ	curred a	at the time, date and place	, and due to the cause(s	s) and manner as stated.					

edical	29a. Certifier (Check only one)	2 Medical
ž	29b. Signature and	title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Num	D35254	6/26	107
Name and address of person who completed cause of death (Item 23a) (Type, Print)	Tenten ONE BALT	imore	mp21229

29d. Date signed (Month, Day, Year)

State Registrar

To the Funeral I

24

within 2.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Marylan		irtment of H <i>tificate of I</i>		_	giene Reg. No.	97	20909
	Physici		1. Decedent's Name (First, Middle, Las Alton J Yocke					2. Date of De. Month 06	ath /2 5 /20	07 ^{Year}	3. Time of Death 11:34 Ам
E	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			Location of Death		4c. Cour	ity of Death	
	Funeral		Baltimore Washir 5. Social Security Number 6. S	ex 7. Age (In yrs. I		Glen B	If Under 24 Hrs.	8. Date of Birt	h		place (State or Foreign
	Director		215-24-8460 1 Usual Residence of Decedent	[™] 2□ F 79	Yrs.	Months Days	Hours Min.	1/18/7 19	28 ^{ar)}	Cou	MD_
	aryland show		10a. State 10b. County	10c. City	, Town or Loc	cation					10d. Inside City Limits
	the Ma	Director	MD Anne Art	undel Pas	adena	10f. Zip Code			10g. Citizen o	of What Cour	1 Yes 2 XNo
	th with 23a or	al Di	105 Altona Avenu	ıe		21122			USA		,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Internal: If team 27 is marked other than "natural; or Itams 23a or 28a-f show important: If team 27 is marked other than "natural be notified at any injury or other traumatic event, the Modical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba □ Yes 2 X No	ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Spec	ace - Americack, White,	
21215-0036	72 hou 'nstura dical E	eted	15. Decedent's Ed (Specify only highest gra	lucation	16a. Deced	ent's Usual Occupa	ation during most of worki	na	16b. Kind of		
121	within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Carpe		during most of worki l)		AA Co	Publ	ic Schools
nd	be filed ntal Hygi of other event, I	BeC	17. Father's Name (First, Middle, Last)		ourpe		18. Mother's Name		Maiden Suma		10 30110013
ızyla	should nd Men marke umatic	ဥ	Alton J. Yockel 19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a	Flora E.			n State Zir	2 Code)
, Ma	and 2 sealth ar n 27 is		Carolyn M. Yockel,	/Spouse	105 A	Altona Av	enue, Pas	adena,			
Baltimore, Maryland	Pages 1 ment of Hitant: If iten jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Removal from State Met	emetery, crem	sition (Name of patory or other place ematory	6/26	/07	Baltim		
Ball	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	7 /	31	Name and Addres	ain Rd	Pasaden	a MD		me, P.A.
The last	Physician /Medical Examiner	-	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a INE GENE	Do not ente	er the mode of dying	g, such as cardiac of lana folls Ols E	r respiratory ar	rest,		Approximate Interval Between Organ and Death Years Years
68760, <	ficate be executed 3 physician and ss the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequent.	,						
O Box	eath certi	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnan 1	death 3 🗌	Ectopic pregnancy Other (specify)				Date of deliver	ery Day Year
rds, P	quires tha n signed I uld be det	þ	Part II. Other significant conditions o	ontributing to death but not resu	ilting in the un	derlying cause give	en in Part I.	23e. Did to			he cause of death?
Vital Records,	i: The law requires that the cate has been signed by th page 2 should be detache	Completed						24a. Was autop perfo 1 Yes		o. Were auto prior to co death? 1 \(\sum \text{Yes}\)	opsy findings available impletion of cause of
	nysiclan: Th	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ ✔ ♠ ♠	Hospital: 1 ☐ Inpatient 2 ☑	ENOutpatient	3 DOA Othe	26. Place of Death er: 4 ☐ Nursing Hor			ther (Specif	60
0 0	ding Phy h. After thi funeral	Ion; T	27. Manner of Death 1 Ratural 5 Pending	(Month, Day Year)	28b. Time of Injury	28c. Injury Work	at c?	28d. Describe h			,,
Division of	deat deat tor: / the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined				Yes 2 □ No	28f. Location (5 City or Tox		mber or Rura	al Route Number,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Ph 2 Medical Exam	ysician: To the best of my know iner: On the basis of examinate and manner stated.	vledge, death ion and/or inv	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	and due to the ed at the time,	cause(s) and r date and place	manner as s e, and due to	tated. o the cause(s)
	To the To the Complet	Σ	29b. Signature and title of certifier	4 Sh	uf	29c. License	20091		29d. Date sign	ed (Month,	Day, Year)
	(d)		30. Name and address of person who	onsity 14	11 Ma	-11sa /	lak D.	rive (ola l	Jorny	md, 21061
	Sta Registr		JUN 2 8 2007	32. Registrar's Signat	ure 246			ŧ			Ī

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Veronica Doris Ziegler 06-26-2007 04:00AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 521 Cleveland Road Anne Arundel Linthicum If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Yea Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖾 F 90 Director 215 07 7987 07-14-1916 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director Anne Arundel MD Linthicum 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 23a 521 Cleveland Rd. 21090 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☑ No Specify: ģ 3 Nidowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) the Accountant Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event once. Herbert Esslinger Bertha Paul ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Tom Ziegler / son 913 Hammonds Lane; Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Meadowridge Memorial | 06-29-2007 | Elkridge, MD 22. Name and Address of Facility Singleton Funeral Home, PA 21. Signature of Funeral Service Licensee MO1459 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 17000 MYOCAROIG /Medical Due to (or as a consequence of): **Examiner** 2041 Dus to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) physician al Division or Vital Records, P.O. Box 68760, Physician/Medical as attending p for use as IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4 Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown s been signal Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2 100 certificate ha 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death. 6 Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

17AV13

CAMP MINMIN AN

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06 **Physician** 2007 7 LAWRENCE ALKIRE 1330 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner WMHS - MEMORIAL HOSPITAL CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 88 Director 218-16-3826 DEC. 22,1918 WEST VIRGINIA Usual Residence of Decedent r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No WV FORT ASHBY MINERAL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or HC 86, BOX 32 26719 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 X Yes 2 No If Yes, Give Year or Dates: \ 1 Never Married 2 Married 'natural", or 1 ☐ Yes 2X No 20c. Location - City or Town, State FORT ASHBY, WV Approximate interval Between Onset and Death Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** CEBU 2201 MARIA 10 0 റ 8 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday Social Security Number 6. Sex **Funeral** 12/19/1918 1 🗆 M Cuba 88 Director 014-44-0458 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ence. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Director Anne Arundel Annapolis MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21409 USA 1726 Deacon Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes A No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No Specify: white Specify: Cuban Completed by 32 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evangelina Vega Julio DeCespedes ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Annapolis, MD 21409 1726 Deacon Way Ana Marie <u>Phillips Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/13/2007 Eastlawn Cemetery Easthaven, Conn 22. Name and Address of FacilitHardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 6Wc 00 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) adical

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar signed by the a d be detached f has e 2 page 2

The law requires that the death certificate be executed

or Attending nours after death.

neral Director: / death.

To the Hospital within 24 hours a

To the Funeral I

Division or Vital Records, P.O. Box 68760,

funeral

ysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregn 1□Live birth 2□Feta 4□Pregnant at time of o	al death 3 ☐ Ectopic preg			23d. Date of delivery Month Day Year
ed by Pn	Part II. Other significant conditions	contributing to death but not res	sulting in the underlying cau	ise given in Part I.	23e. Did tobacco u 1 ☐ Yes 2[se contribute to the cause of death?
отріет					24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
o pe	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2]ER/Outpatient 3 □ DOA	Othor	ath (Check only one) Home 5 ☐ Residence	G □Other (Specify)
TION:	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred
erillic	3 Suicide 6 Could not I 4 Homicide determined		ome, farm, street, factory,	office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
lical		Physician: To the best of my knoaminer: On the basis of examination				and manner as stated. I place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

JUN 1 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. bistrar's Signature For State

_	_		1
	Reg.	No.	6

		Registrar				Ce	rtificate	of i	Death			Reg	g. No. 🦳	1 6 1	6
Physicia		1. Decedent's Name (First, Middl	e, Last)								2. Date o		Day	Year	3. Time of Death
/Medica		Patsy Lee Adki	ns								June		2007	rear	11:00am
Examine		4a. Facility Name (If not institution	n, give street a	and numl	per)		4b. City, To	wn, o	r Location	of Death			4c. Count	y of Death	,
		11453 Longwood	Road				Easto	n					T	albot	
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2		. Age (In yrs.			Year Days	If Under Hours	24 Hrs. Min.	8. Date o	f Birth , Day, Y	Year)	9. Birthp	lace (State or Foreign try)
Director		215-38-2036	1 L W 2	A	67	Yrs.		-,-			June			Mary.	
pu »	-	Usual Residence of Decedent 10a. State 10b. County			10c Cit	y, Town or Lo	ocation			_					04 124- 02-12-2
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he M 8a-f		Maryland Talb	ot		E	aston						,			
Vith the	Director	10e. Street and Number					10f. Zip C					100	g. Citizen of	What Cour	itry?
s 23g	ā	11453 Longwood							.601					S.A.	
er de item	runerai	11. Marital Status	Arı	as Deced med Ford]Yes 2	ent Ever in U	.S. 13.	Was Deceder If Yes, specify	t of H	lispanic Ori an, Mexica	igin? (Spe n, Puerto	cify Yes o Rican, etc.	r No- .)		ice - Americ ack, White,	
s aft	Ş	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	lf Y	es, Give ar or Dat	77] IND		1 ☐ Yes 2	No	Specify:				Speci	ify: T.	Thite
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in 72	Сотріете	(Specify only highe	st grade com			(Give	kind of work DO NOT use	done i	during mos	st of worki	ng	- 1	ob. Ring of L	343111E33/1110	dustry
with iene than	E	Elementary/Secondary (0-12) 06	Co	llege (1-4	for 5+)		emaker						own :	home	
other ent,	De C	17. Father's Name (First, Middle,	Last)						18. Mothe	er's Name	(First, Mic	ddle, Ma	aiden Surna	me)	
lid be ked ic ev	0	Sonny Squires							Sac	ddie	E. Fe	ergu	son S	quire	S
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relations	ship (Type. Pri	int)		19b. Maili	ng Address (S	treet	and Numb	er or Rura	il Route N	umber, (City or Towr	n, State, Zip	Code)
s 1 and 2 should be filed within 72 hours after death with the Manylan f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		George E. Adkin	s. Jr.	/ so	n		53 Lon						Mary		
s 1 a c c c c c c c c c c c c c c c c c c	-1	20a. Method of Disposition			20b. I		osition (Name matory or other				ate		Oc. Location		
Page ent o ent o y or		1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (5		al from St	late		Cemete			06/20	/07	g	ddaal:	. Ma	ryland
nit. I	1	21. Signature of Moneral Service			KI	2	2. Name and	Addre	ss of Facili	ty					
permit. Pages 1 and 2 st permit. Pages 1 and 2 st Department of Health and Important: If them 27 is r any Injury or other traun once.	- 1	1/20	1			F1	eegle .	and	l Helf	fenbe	in Fu	iner	al Ho	me, P	A
_	\forall	23a. Part1. Enter the disease, o shock, or heart failure. List	r complication	s that car	used the deat	h. Do not en	Box 1	of dyir	ng, such as	e cardiac o	r respirato	rv arres	tand :	21639	Approximate
Dhysisian		shock, or heart failure. List Immediate Cause (Final	t only one cau		ch line. タクムー		1602 8-								Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a		r as a conseq		, C-AC [-							>	CAN
Examiner				oue to (o	as a conseq	derice or).									
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uted Insit		cause. Enter Underlying Cause (Disease or injury	8												
exect and and and all-tra	Examiner	resulting in death) Last	c	Due to (o	r as a consec	uence of):	·								
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certificate be executed ding physician and ise as the burial-transit	//medical		u												
nding use a		IF FEMALE: 23b. Was decedent pregnant			ome pf pregn		_						23d. D	ate of delive	erv
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s that		Part II. Other significant conditi				ulting in the u	nderlying cau	se giv	en in Part I	l.	23e. [Did toba	icco use cor	ntribute to th	ne cause of death?
quire n sig	<u> </u>	Lund 1	CANL	IR.							1	X Yes	2 No	3 Prob	ably 4 Unknown
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he la	Ĕ										8	autopsy performe	ed?	prior to cor death?	inpletion of cause of
ifficat		25. Was case referred to medica	1						00 81	of Doods	1 Y		X No	1 ∐Yes	2□No
s cert	0 0	examiner? 1 ☐ Yes 2 ZNo	Hospita	ıl:	patient 2	ER/Outpatie	at 3 🗆 DOA	Oth			(Check o				
P Salphis	0	27. Manner of Death	288	a. Date of	Injury	28b. Time o		lnjur Wor	4 🗆 100				ce 6 Ot		<u>//)</u>
th.: After	100	1 X Natural 5 ☐ Pendir 2 ☐ Accident investi	ng gation	(Month	, Day Year)	Injury	М		ƙ? Yes 2□				,,		
Atter dea ector	20	3 ☐ Suicide 6 ☐ Could		. Place o	f injury - At h	pme, farm, st	reet, factory, c	ffice		2	28f. Location	on (Stre	et and Num	ber or Rura	l Route Number,
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splta nours inera y fille		29a. Certifier 1 📉 Certifyii	ng Physician:	To the b	est of my kno	wledge, deat	h occurred at	the tir	ne, date ar	nd place, a	and due to	the cau	use(s) and m	nanner as si	tated.
n 24 h	Medical	(Check only 2 Medical one)	Examiner: O	n the bas	is of examina	ation and/or ir	vestigation, ir	my c	pinion, dea	ath occurr	ed at the t	ime, dat	te and place	, and due to	the cause(s)
To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for the funeral director.	M	29b. Signature and title of certifie	er				29c. L	icens	e number			290	d. Date sign	ed (Month,	Day, Year)
		€. /Dem	-out	Le-			1	V'	02	91			0	6/1	9/2007
	-	30. Name and andress of person		ed cause	of death (Iter	n 23a) (Type.								. /	
		Eric Hermansen					.; Go1	dsb	oro,	Mary	1and	216	36		
State	е	31. Date filed (Month, Day, Year)			nintrar's Cian	aturo	11.011					-			
Registra	r	JUN 1 9	2007		and A		Special Control								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

	State of Maryland / Department of Health and Mental Hyglene Certificate of Death Reg. No. 0 0 7	20914
Physician	1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	3. Time of Death
/Medical	4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	5 pm
Examiner	Deven manor Cumbuland my allegans	A
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birth	lace (State or Foreign
Director	Usuat Residence of Decedent Usuat Residence of Decedent	YLAND
show		0d. Inside City Limits 1 Yes 2 No
the Ma 28a-f s notities	10e. Street and Number 10f. Zip Code 10g. Citizen of What Coun	
th with the same or 3 and or 3 and 5	220 SOMMERVILLE AVENUE 21502 U.S.A.	шуг
020 urs after dea si; or itams Examiner m by Funel	If Yes, Give 1 Yes 2 Al No Specify: WHIT	etc.
15-0020 72 hours aft "naturel; or edical Enameleted by F	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Ind	dustry
121215-0(led within 72 hou sygiene. Ner then "nature the wedical int the Medical Completed	Elementary/Secondary (0-12) College (1-4or 5+) 2 REGISTERED NURSE NURSING	
be filed tal Hygin d other event, the Be Cc	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
arylar should be nd Menta merked umetic ev	EARL PECK GLADYS COOPER	
Maryland 21215-0020 d 2 should be filed within 72 hours aft th and Mental Hygiene. 7 is marked other than "naturel; or traumatic event, the Medical Exert traumatic Event, the Medical Exert To Be Completed by F	19a. Informant's Name/Relationship (Type, Print) KARI SPATARO / DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 15610 YODER COURT, S.W., CUMBERLAND, MD	Code) 21502
there is a second secon	20a. Method of Disposition 20b. Place of Disposition (Name of particular place) 20c. Location - City or To	
Pages Pages nent of h	1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HILLCREST MEMORIAL PARK 06/18/2007 CUMBERLAN	D, MD
Baltimore, Maryland 21215-0 permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany linury or other traumatic event, the Medical page. To Be Completed	21. Signature of Funeral Service Licensee 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD	21502
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Physician /Medical	Immediate Cause (Final	Onset and Death
Examiner	disease or condition resulting in death) Due to (or as a consequence of):	Luch
iner in a contract of the cont	Joseph abscen	Luch
Box 68760, want certificate be executed ethending physician and for use as the buriel-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate	
68760, ificate be exe g physician e as the buriel-ledical Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Due to (or as a consequence of):	
- = 50 00 =	resulting in death) Last	
Boy aath ce ettend for us		
O. Ithe de by the ached	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to	bably 4 Unknown
S, Flash that igned be def	The liebarres parcyloperes	
Division of Vital Records, P.O. Box or Attending Physicien: The law requires that the death cert effer death. Director: After this certificate has been signed by the ettending in by the funeral director, page 2 should be detached for use ertification: To Be Compieted by Physician/M	Clarbote curboses 1 Yes 2 No 3 Prol 2 No 3 Prol 3 P	dere eutopsy findings vailable prior to completion of cause death?
The la ate ha page ?	1 ☐ Yes 2 ☐ N o 1 ☐	□Yes 2□No
Vita Iclen: certific rector,	25. Was case referred to medical examiner? 1. Very 2. September 2. Se	
Of Physerthis eral dii	1 Yes 2 No. 1 Inpatient 2 ER/Outpatient 3 DOA No. 1 No. No	у)
nding ath. or: Afte he fun	1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No	
	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify) 28f. Location (Street and Number or Rure City or Town, State)	al Route Number,
Dir To the Hospital or within 24 hours effe To the Funerei Dir completely filled in Medical Ceri	29a. Certifier (Check only one) 1—CertifyIng Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es s (Check only one) 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to and manner stated.	tated. o the cause(s)
Fo the vithin 2 Fo the comple		Day, Year)
F > F 0	D6017565 Jun 14.	2007
5	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month), 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 J - Re (I i no 9 + +	
State Registrar	31. Date filed (Months Pay Year) 2007 32 Registrar's Signature	

			. For	State of Mar	yland / Dep	artment of H	lealth and M	1ental Hy	giene 🍦	Car and	11 - 1
			State Registrar		Ce	rtificate of L	Death		Reg. No.	Udi	
	Dhyoic	ion	1. Decedent's Name (First, Middle,	Last)				2. Date of Do Month	eath Day	Year	3. Time of Death
	Physic Medi/		ROBERI	CAIRI	VES	BAY		June		2007	3:30 PM
	Exami		4a. Facility Name (If not institution,			4b. City, Town, or	Location of Death		4c. Cou	inty of Death	
			Stella Maris				monium			Balti	
- 6	Funeral		5. Social Security Number 212–26–8183	. Sex 7. Age (1 M 2 ☐ F	In yrs. last birthday) 77 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	rth ay Year)	Coui	
	Director		Usual Residence of Decedent	177	- ((7/29	/1929	Ma	ryland
	laryland show		10a. State 10b. County	1	0c. City, Town or Lo	ocation				1	10d. Inside City Limits
	a-f st	ctor	MD. Har	ford		Ja	rrettsv	ille			1 ☐ Yes 2 📶 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?
	ath w		1800 Furna	ce Road			21084			ted S	
	er de	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)	o- 14. I	Race - Americ Black, White,	
36	s after	by F	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	d 1 □ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Spe	ecify:	
9	tural	edk	15. Decedent's		16a. Dece	dent's Usual Occupa	ation		16b. Kind o	₩. f Business/In	hite
15	nin 72 n "na Medic	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of work)	ing			,
212	d with giene gr tha the I	E O	6	College (1-401 5+)		Plumb	er		P.	lumbi	ng
D	al Hy l othe	Be Completed	17. Father's Name (First, Middle, La	nst)			18. Mother's Name	e (First, Middle	e, Maiden Suri	name)	
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notifited at	2	Walker	Mason	Bay	r	Addie		Roath	R	obinson
a	2 sho and is mi		19a. Informant's Name/Relationship					al Route Numi	ber, City or To	wn, State, Zip	Code) 21084
	and lealth m 27 her tr		Dorothy V. Ba			Furnac			ettsv:		
Ore	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation _ 3	[□Removal from State]		osition (Name of matory or other place		Date -		on - City or To	
Baltimore,	t. Pa tmen tant: njury		1 Burial 2 Cremation 3	A 1		Mem. G		5/07			Maryland
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural"; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service/Li	tensee		2. Name and Addres	υa	rrett:	sville neral	e, Ma:	ryland
	15-18		23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that su sed th	e death. Do not en					Home	Approximate Interval Between
	Physician	П	Immediate Cause (Final disease or condition	200	Λ ΡΟΤΙΙΟΎΤΙ	VE PULMON	ADV DICE	A C E			Onset and Death
	/Medical		resulting in death)	Due to (or as a c		VE TUENON	AKI DISE	ADE			
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MA	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a c	onegationed of):						
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387		dical		d			·				
×	eath certif attending for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome pf	pregnancy				234	Date of delive	2004
Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 l 4 Pregnant at tin	Fetal death 3[ne of death 5[Ectopic pregnancy Other (specify)			200.	Month	Day Year
P.O.	t the oy the achec	hysi	9 Unknown	9□Unknown							
ري ت	The law requires that the death certifier has been signed by the attending tage 2 should be detached for use as	by P	Part II. Other significant condition	s contributing to death but r	not resulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use c	ontribute to the	he cause of death?
ğ	w require been sig should b	edk						10	Yes 2□ N	o 3□ Prob	oabły 4 XI Unknown
သ	law requas been 2 shouli	plet						24a. Was		b. Were auto	psy findings available
Ä		Completed						auto perf	ormed?	death?	mpletion of cause of 2□No
Vital Records,	hysician: The law his certificate has t I director, page 2 s	Be C	25. Was case referred to medical examiner?				26. Place of Deat				
> >	Physic this ce al dire	은	1 ☐ Yes 2 📉 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie		4 Nursing Ho	me 5□Res	idence 6X	Other (Specif	HOSPICE
n	Attending Physician: r death. ector: After this certifics by the funeral director, p	ü	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	Work		28d. Describe	how injury oc	curred	
S.	tend leath. tor: /	cati	2 Accident investigat 3 Suicide 6 Could no	ha	AAA aaraa fa aaa ah		Yes 2 □ No	001	· · · · · · · · · · · · · · · · · · ·		
Division or		Certification:	4 ☐ Homicide determine	ed 28e. Place of injury building, etc. (- At nome, farm, sti Specify)	eet, ractory, office		City or To	Street and Nu wn, State)	ımber or Rura	al Route Number,
	Hospital or the hours afte Funeral Dir tely filled in		29a. Certifier 1X Certifying	Physician: To the best of r	ny knowledge, deat	h occurred at the tim	ne, date and place,	and due to the	e cause(s) and	I manner as s	tated.
	n 24 I n 24 I he Fu	Medical	(Check only 2 Medical En	caminer: On the basis of examiner states	kamination and/or ir	vestigation, in my o	pinion, death occur	red at the time	, date and pla	ce, and due to	o the cause(s)
	To the within 2 To the complet	ž	29b. Signature and tipe of certifier)		29c. License	number			ned (Month,	
				10		100	13721	_	6	121/	クフ

15 State

Registrar

ROBERT BAY

Baltimore, Maryland 21215-0036 JUNE 21, 2007 3:30 p.m.

> DR. TARIQ MAHMOOD
>
> 31. Date filed (Month, Day, Year) JUN 2 8 2007

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤉 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** BEEMAN 21 2007 06 1846 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Kings Grove Road Corriganville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 17, 7. Age (In yrs. last birthday, Social Security Number 9. Birthplace (State or Foreign **Funeral** Months Hours Days Min 1 □ M 2 □ F МD Director 216-72-6766 50 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the M-di-al Examiner must be notified at Corriganville MD Allegany 1 ☐ Yes ≩ ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. Box 81 21524 USA filed within 72 hours after death v Hygiene. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Bace - American Indian. Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Widowed 4 Divorced white Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Surplus City laborer permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 Is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Clites Clarence Clites ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P O Box 81 Corriganville MD 21524 19a. Informant's Name/Relationship (Type. Print) Robert Beeman husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 6/25/2007 Restlawn Memorial Gardens LaVale MD 5 Other (Specify) 22. Name and Address of Facility Scarpelli Funeral Home, PA 21. Signature of Fundral Service 108 Virginia Avenue: Cumberland, MD 21502 23a. Juni 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition leimynsar come **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day 5 Other (specify) ed by the a detached for 1 ☐ Yes 2 ☐ No 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 🔑 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined within 24 hours a To the Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar

AVE, CUMBERLAND MD 21502

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AFAQ AHMAD, 625 KENT

JUN 2 8 2007

31. Date filed (Month, Day, Year)

D60478

06-22-2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Sarah Cathrine Brunner 12 15 fm June 007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Boonsboro Fahrney Keedy Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Hours Min 1 ☐ M 2 🖾 F Days Director 219-12-2331 02-01-1922 Maryland 85 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f ahow other traumatic event, the Medical Evantinat must be notified at 1 ☐ Yes 2 No Boonsboro Directo Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Depurment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 2 any nijury or other traumatic event, the Medical Eventical Persons. United States 8507 Mapleville Rd, Boonsboro, MD 21713 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bessie Ellen Hose Isaac Josephs Trumpower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21769 2 Derr Ln., Middletown, MD Carol Storm, Personal Rep. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg, Maryland 504 Main St, P.O.B. 136 Smithsburg Crematorium ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature TFuneral Service Licensee Myersville, MD 21773 Ricketts Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (onges Heav **Physician** 64 disease or condition resulting in death) /Medical Due to (ocas a consequence of): Examiner Obst hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner dh burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical the use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliven 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 SPProbably 4 ☐ Unknown should 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one, Hospital: Other: 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) the funeral 28c. Injury at Work? 27. Manner of Death 28b Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide filled within 24 hours a To the Funeral C completely filled i To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opal Court, Hagerstown, MD Khalid Waseem, MD 31. Date filed (Month, Day, Year) JUN 2 8 2007 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Anne Louise Burnell Year P^{M} June 10 2007 6:40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 213-30-5668 1 □ M 2**X** F 77 Nov. 13, 1929 unknown Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Maryland Anne Arundel Edgewater 1 Tyes 2 Two 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21037 2976 Edgewater Drive U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes **2CX**No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Agent U.S. Navy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Adene Soelberg Nathaniel A. Burnell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jessica Andrews/cousin 6825 North Chaparral Avenue Tucson, AZ 85718 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 6/14/2007 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature uneral sery e Licenses 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Conges/Ive Year ue to for as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show idical Examiner must be notified at

the Medical

than

marked other

permit. Pages 1 and 2 should be file
Department of Health and Mental Hy
Important: If Item 27 Is marked othe
any Injury or other transment

within 72 hours after

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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attending physician

certificate has

Phospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice

within 2

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical Completed by Be Certification: To

Medical

Cause (Disease of Injury that initiated events resulting in death) Last	C	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Par	t I. 23e. Did tobacco use contribute to the cause of death?
Hypoxia Breast ca	ncer	24a. Was an autopsy performed? 1
25. Was case referred to medical	26. Pla	ice of Death (Check only one)
examiner? 1 Yes 2 No	Hospital: 1 ☐ Hapatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ I	Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of lnjury 28c. Injury at Work? 1 □ Yes 2 [28d. Describe how injury occurred
3 Suicide 6 Could not be determined	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, death occurred at the time, date iner: On the basis of examination and/or investigation, in my opinion, d	and place, and due to the cause(s) and manner as stated. death occurred at the time, date and place, and due to the cause(s)

State Registrar

29d. Date signed (Month, Day, Year)

30. Name of person who completed cause of death (Item 23a) (Type, Print

Hery Annapolis, wol.

JUN 13 2007

29b. Signature and title of certifier

			Pleas	e Type or Pri							•	
			For	State of Ma					Mental Hy	/gien	е	
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₹.	Physici	an	Decedent's Name (First, Middle,		D - 1.6.				2. Date of D Month	Da	Year	3. Time of Death
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	death	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	3. 13.		Hispanic Origin? Iban, Mexican, Pu	(Specify Yes or N		14. Race - Amer	
5-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	5	1 ☐ Never Married 2 ☐ Marrie 3 🔀 Widowed 4 ☐ Divorced				1 ☐ Yes 212 N		erio nican, etc.)		Black, White Specify: Wh	
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Baltimore, Maryland 2121	permit. Page Department of Important: If any Injury or once,		21. Signature of Funeral Service I	icensee		4	2. Name and Add			5308	Backl	ick Rd,
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ŧ.			23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	only one cause on each li	ne.	/ 7	er the mode of d	ying, such as card	ac or respiratory	arrest,		Interval Between Onset and Death
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		Com							per 1□ Yes	formed?	death?	2√2 No
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification of the Funeral director, tompletely filled in by the funeral director,	Medical C	29a. Certifier Check only one)	Physician: To the best examiner: On the basis of and manner st	of examinati	vledge, deat ion and/or in	h occurred at the	time, date and pla opinion, death or	ce, and due to the	e cause(e, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the	Me	29b. Signature and title of certifier	0			29c. Lice	nse number		29d. Da	ate signed (Monti	n, Day, Year)
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,	1		30. Name and address of person v	ho completed cause of c	death (Item	23a) (Type,						
			AMILON COM	MES W	67	01 N.	Charl	is St	DWSUN	/ ^	1) 42	ey
	Sta Registi		31. Date filed (Month, Day, Year)	32 Registr	rar's Signati	ure	188					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 10 Day Audrey C. Bardell June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Center Anne Arundel Severna Park 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) July 17,1920 **Funeral** 7. Age (In yrs. last birthday) Days Hours 1 □ M 2X F 329-14-5003 Director 86 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location ral", or items 23a or 28a-f shov Examiner must be notified at Director MD Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 613 Cedarwood Lane 21032 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No 2 Specify: 3X Widowed 4 ☐ Divorced er than "natur, the Medical E Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Shell Oil Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas White Vivian Dales ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John T. Bardell / son 613 Cedarwood Lane Crownsville, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
important: If ite
any Injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 06/13/2007 Brentwood, MD. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD. 1)ou 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a correquence of): /Medical Examiner orillation ria Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dement sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician I for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown cate has been signed page 2 should be del 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 6-17-07

21061

Month

Day

1 ☐ Yes 2 ☐ No

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

1 □Yes No

Illinois

White

21032

20715

Approximate Interval Between Onset and Death

weeks

years

Year

Black, White, etc.

9:30 A M

2007

State Registra

Medical

31. Date filed (Month, Day, Year, JUN 1 3 2007

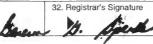
4 Homicide

(Check only

29b. Signature and title of certifier

Mirza Nusairee

29a. Certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

1401 Madison Park Rd.

29e. Lisense number D 00 405 19

Glen Burnie, MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician EDWARD** Eugene BELL 06 23 07 2:56 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 8. Date of Birth OCL. 11, 1934 Social Security Number 7. Age (In yrs. last birthday) 72 Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral ™** 2 □ F Months Days Hours Min. Maryland 226-42-8718 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany MD. Director Westernport 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22513 Horserock 21562 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 XYes 2 No If Yes, Give Korean Year or Dates: 1 ☐ Never Married 2 X Married white Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Paper Manufacturer Superintendent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas James Bell SR Margaret Ellen Elkins ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22513 Horserock Road, Westernport, Maryland 21562 C. Belle Bell/ wife altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town. State 06/28/ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lonaconing Maryland Oak Hill Cemetery 4 Donation 5 Dother (Specify) 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ocential Mu **Physician** cut mutes /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): physician the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No 2 No or Attending Physician; funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Hnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. within 24

Division or Vital Records, P.O. Box 68760, Hospital the

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VA State

Registrar

DHMH 17 Rev 1/2001

Ian

29b. Signature and title of certifier

Jesus

21244

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mark Ryan Climaco Caguioa 24. 2007 3:57 P May /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda nder 1 Year | If Under 24 Hrs. hths Days | Hours | Min. Montgomery

9. Birthplace (State or Foreign Country) National Naval Medical Center 8. Date of Birth (Month, Day, Year) 6/1/85 5. Social Security Number 7. Age (In yrs. last birthday) If Under **Funeral** Months NOXM 2□ F 21 555**-**85-4523 California Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ital Hygiene. od other then "netural", or Items 23a or 28e-f show event, the Medical Exprises trast Le notified at CA San Joaquin Stockton 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1633 E. Bianchi Road 95210 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 2007 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural", or item any injury or other treumatic event, the Mental and once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 No Specify: Filipino Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Army 12 Soldier 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rodolfo Caguioa Maria Lourdes Climaco ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria L. Climaco/Mother 1633 E. Bianchi Rd. Stockton, CA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State San Francisco Nat Cemetery 6/2/07 San Francisco, CA * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Murphy Funeral Home 4510 WilsonBlvd.Arl. 22203 deer 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** COMPLICATIONS OF BLAST INJURIES /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760 physician the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year ó in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by page 2 should be 2 No 1 🗆 Yes 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 5₹ Yes 2 □ No 24a. Was an autopsy performed 1 X Yes 2□ No director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1X Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA funeral Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 3:55 р м 1 Natural 5 Pending investigation 1X Yes 2 No DURING MILITARY OPERATIONS 5/4/07 24 hours after death e Funerel Director: / 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 XHomicide BATTLEFIELD SOUTH BAGHDAD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe June 11, 2007 M. D. D34086 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARMED FORCES INSTITUTE OF PATHOLOGY STEPHEN ROBINSON MC CAPT USN

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day 1987)

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1:30 P June 12, 2007 K. Domingo Canlas 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 112 Eagle Head Drive Ft. Washington Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 12, 1920 9. Birthplace (State or Foreign 563-27-5850 Months Days Hours 1 ▼ M 2 □ F 87 Philippines Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2√No Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 Eagle Head Drive 20744 USA 14. Race - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 210 (No Specify. Specify: Filipino 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Accountant Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pedro Canlas Feliciana Kabigting 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Τ. Canlas / Wife 112 Fagle Head Drive Ft. Washington, Maryland

Date

06/15/2007

20c. Location - City or Town, State

Clinton, Maryland

Temple

Hills, MD

Physician /Medical

Physician

/Medical

Examiner

10a. State

Maryland

Leonora

20a. Method of Disposition

Wa Burial 2 ☐ Cremation

4 □ Donation 5 □ Other (Specify)

3 ☐Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard Su

32. Registrar's Sign

Nicere 31. Date filed (Month, Day

JUN 1 4 2007

Director

Funeral

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Completed

Be

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Funeral

Director

Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be

Examiner Examiner

The law requires that the death certificate be executed attending physician and for use as the burial-tran Completed by Physician/Medical signed by the a Id be detached f cate has l To the Hospital or Attending Physician: Be Certification: To After th within 24 hours after death.

To the Funeral Director: A completely filled in by the fi Medical

Division or Vital Records, P.O. Box 68760,

21. Signature	M - Kula	nsee	George 6160 Oxo	P. Kalas Funer on Hill Rd., Ox	al Home, P.A on Hill, MD :	20745	
shock, or hea	rt failure. List only	plications that caused the dear one cause on each line.	th. Do not enter the mo	de of dying, such as cardia	ac or respiratory arres	t,	Approximate Interval Between Onset and Death
Immediate Cause (disease or condition resulting in death)			nsion				Oriset and Death
		Due til for as a consec	quence of):				
Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or	mediate	Due to (or as a consec	quence of):				
that initiated events resulting in death) L		CDue to (or as a consec	quence of):				
		G					
IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	23c. If yes, outcome pf pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of of	al death 3 Ectopic p			23d. Date of de Month	livery Day Year
	nentions	contributing to death but not res	sulting in the underlying o	cause given in Part I.		cco use contribute t	o the cause of death?
					24a. Was an autopsy performe	ed? death?	utopsy findings available completion of cause of
25. Was case referr	red to medical			26. Place of De	ath Check only one)		
1 Yes 2 1			ER/Outpatient 3 Do	OA Other: 4 Nursing	Home 5 - Residen	ce 6 □Other (Spe	ecify)
27. Manner of Death 1 ☐ Natural 2 ☐ Accident	5 ☐ Pending investigatio		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	e 28e. Place of injury - At h building, etc. (Speci	ome, farm, street, factor fy)	y, office	28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
29a. Certifier (Check only one)	1	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and place, in my opinion, death occ	ce, and due to the cau curred at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
29b. Signature and	title of certifier	0 1	29	c. License number	290	I. Date signed (Mon	th, Day, Year)
1	1 coli	Richards	2 D.O. F	1006078	1 0	rune 13	12007

20b. Place of Disposition (Name of cemetery, crematory or other place)

Resurrection Cemetery

State

Registrar

Old Branch Are

6109

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2007 **Physician** 0700 James W. Carter 13, June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Caroline 309 Gardens Court Federalsburg If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 1**X** M 2 □ F 86 426-38-6767 Director Jan. 21. 1921 Mississippi Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar and any injury or other traumatic event, the Medical Examinar and any injury or other traumatic event, the Medical Examinar and any injury or other traumatic event, the Medical Examinar and any injury or other traumatic event, the Medical Examinar and any injury or other traumatic event, the Medical Examinar and any injury or other traumatic event, the Medical Examinar and any injury or other traumatic event, the Medical Examinar and any injury or other traumatic event, the Medical Examinar and Examinar 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Caroline Federalsburg 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21632 United States 309 Garden Court Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify. Specify: Black ģ 3√Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Citrus & Cannery Elementary/Secondary (0-12) College (1-4or 5+) Factory Worker 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgia Drake ပ Willie Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 105 Old Horse Shoe Lane, Natchez, MS Lillian Carter/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mid-Shore Cremation 6/19/07 Cambridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** oronar ears! /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use coptribute to the cause of death? ð 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2

Division or Vital Records, P.O. Box 68760. e Hospital or Attending Physician: 24 hours after death. e Funeral Director: After this certifica letely filled in by the funeral director, p. To the P within 24 To the P

27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mpleted cause of death (Item 23a) (Type, Print) Teal Dr. Sufe 204 Easton, MD

State Registrar 31. Date filed (Month, Day

8221

.0.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 2:30 PM 2007 DX 01na /Medical 4c. County of Death give street and number) 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death Examiner 7amballs mre Mighway If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M **XX**F Yrs. 3/8/1946 West Virginia Director 217-44-3950 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes XXNo Director Anne Arundel **Gambrills** 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1621 Defense Highway 21054 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Never Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify White Specify: 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent d 2 should be filed w th and Mental Hygler 7 is marked other tf traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Virgil Everett Mullens Dora Louise Jarrell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is r any Injury or other traur Gambrills, MD 21054 1621 Defense Highway Bilbie R. Cox Husband altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 Removal from State Metro Crematory 6/13/2007 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Hardesty Funeral Home, P.A. Jak Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** month MG /Medical Due to (or as a con ence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gaus. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed and burlal-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the hintal Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ cate has been sig , page 2 should b 1 Tes 2 🗌 No 3 Probably 4 ☐ Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 21X No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier LKCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUN 1 3 2007

30. Name and a

ORIGINAL

dress of person who completed cause of death (Item 23a) (Type, Print)

600

29c. License number

Juke 300 Annipolis

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month June **Physician** Day 25, 2007 12:15 A M MARGARET VIRGINIA DARNER /Medical 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital 8. Date of Birth (Month, Day Year) April 12, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Maryland Days Months Hours 1 M &F F 88 Yrs. 214-10-5430 1919 Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4521 Elmer Derr Road 21703 U.S.A. Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes No
If Yes, Give
Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White þ Specific 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin Luther Jenkins, Sr. Alice Pearl 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and.
Department of Health
Important: If item 27
any Injury or other tr
once. Jerry E. Darner/Son 4521 Elmer Derr Road, Frederick, MD 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - Cify or Town, State 1 □ Bunal 2 □ Cremation 3 □ Removal from State Lutheran Cemetery, crematory or other 42 ponation 5 □ Other (Specify) June 29, 2007 Jefferson, Maryland onation 5 Other (Specify) 21. Signature of Funeral Service bicens 22. Name and Address of Facility March MQ0021 Keeney and Basford Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, have caused on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALVITE MYOCALDIAL INFARCTION **Physician** WEEK /Medical Due to (or as a consequence of): Examiner INITERATION CVNU DISITAGE 2 YIEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the 1 + attending phy IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No Month Day 4☐Pregnant at time of death 5 Other (specify) s been signed by the sahould be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy perform certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation s after dec. 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1797-4611 JUNE 25, 200+ MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANE # 204 FREDERIKK, MD 21702 1-AME) 1E1 egistrar's Signatur 31. Date filed (Month, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Пау **Physician** Month Year Gordon Orley Driver, Sr. РΜ 2007 9:40 /Medical 10 June 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number If Under 1 Year | If Under 24 Hrs 6 Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months tXXM 2 ☐ F Hours 214-22-2922 81 Director March 28, 1926 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other than "natural" or Isome 220 and a contract of the contra 10a. State 10b. County 10c, City, Town or Location 'natural', or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits Maryland Anne Arundel Annapolis Director 1XYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1210 Van Buren Drive 21403 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. MXYes 2 No If Yes, Give 1944–46 Year or Dates! 1 Never Married XXMarried 1 ☐ Yes 2 🔼 No White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) the 12 Sales Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Edward E. Driver Theresa Hehenberger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other training once. Bertha J. Driver/wife 1210 Van Buren Drive Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Hillcrest Mem. Gardens 6/15/2007 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Maryland 21. Signature of Suneral Service 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 649 disease or condition resulting in death) /Medical Due to (or as a ensequence of) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of burial-tra Due to (or as a consequence of) Physician/Medical the attending IF FEMALE: nse yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy perform certificate l director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 5 Residence 6 Other (Specify) 21110 1 ☐ Yes 2 ER/Outpatient ۵ 1 ☐ Inpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation 12 Natural 2 Accident death. 1 Yes 2 No 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending n 24 hours after death.

Be Funeral Director: A letely filled in by the full completely

Baltimore, Maryland 21215-0036

Registrar

Medical

29a. Certifier

(Check only one)

1CKIA EC

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month. Year) JUN 1.3 2007

29b. Signature and title of certifier

trar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06 **Physician** 20^{'0}7 **LEWIS** DEVORE SR 2030 21 DONALD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 27 9. Birthplace (State or Foreign **Funeral** 216-22-7086 Months Days Hours Maryland 1 ☑ M 2 ☐ F 80 Yrs. Director 1926 Usual Residence of Decedent 10a. State 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits Allegany MD. Westernport Director Y Yes 2 □ No with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 245 Wood St. 21562 United States death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? WW 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or iter 1X Yes 2 ☐ If Yes, Give Year or Dates: ^{2□ No} Korea 1 Never Married 2X Married Specify: white Maryland 21215-0036 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Paper Manufacturer Instrument Technician permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked ofth any Jiny or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Lewis DeVore Ida Elizabeth Close ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald L. DeVore JR/ son 18020 Norman Drive, Fairplay, Maryland altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Philos Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Westernport, Maryland 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Acute clio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 0-Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as attending p IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 ☐ Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 □ Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No perform 2 No 1∐ Yes 2/2 PO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) hpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To After this Date of Injury (Month, Day Year) e Hospital or Attending Pi 24 hours after death. e Funeral Director; After the 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 24 29b. Signature and title of certifier 20 29d. Date signed (Month, Day, Year)

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State

Registrar

300 Scho-31. Date filed (Month, Day, Year)

JUN 2

5 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No To the Hospital or Attending Physician: fo tn.
within 24 hour.
*he Funeral D' Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and time of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)58824 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Paul Donaher, M.D. 119 C. North Main St. Galena, MD. 21635 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

JIII I GIIII GIIII GI		- For State Crivial yiand / Departme - For State Certifica Registrar	ite of Death	Reg.	No. 200	7 2003
Physicia	n/	Decedent's Name (First, Middle, Last)		2. Date of Death Month D	ay Year	3. Time of Death
/ledical Examin		John Walter Furmankiewicz 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	June 24, 200	07 4c. County of Death	1800 hrs
		904 Edmund Street	Aberdeen		Harford	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 1 × M 2 F 60	day) If Under 1 Year If Under 24Hrs Months Days Hours Min	-	Foreig	hplace (State or n untry) RI
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	or Location			10d. Inside City Limits
*	5	MD Harford Aber	rdeen			1 X Yes 2 No
Maryla 28a-f	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	itry?
ith the 23a or notifie		904 Edmund Street 11. Marital Status 12. Was Decedent Ever in U.S.	21001	anifu Von or No	U.S.A.	oon Indian Plant
15-0036 filed within 72 hours after death with the Maryland I Hygiene. d other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married 3 X Widowed 4 Divorced If Yes, Give Year 1962–84	 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 X No specify: 		White, etc. Specify: Whi	can Indian, Black,
urs afte	ą	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of		6b. Kind of Business/I	
136 hin 72 hor ie. than "µa	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use reti vil Service	red)	Emergency	Comm. Oper.
	ပ၂	17. Father's Name (First, Middle, Last)		e (First, Middle, Mai	iden Surname)	
d be fenta	o Be	Casmir Furmankiewicz 19a. Informant's Name/Relationship (Type, Print) 19b	Felici Mailing Address (Street and Number or I	e James	or City or Town State	Zin Code)
MD 2 d 2 shou Ith and M n 27 is n	F		115 Landsdowne Ct.			
	1	Cremato	f Disposition (Name of cemetery, ory or other place)	Date 2	20c. Location - City or	Town, State
Pages nent of ant: I		4 Donation 5 X Other Specify: Entombrent Harfo	· ' '	8/07	Aberdeen,	Marvland
Baltimore, pemit. Pages I an Department of Her Important: If ite		21, Signature of Funeral Arvice Licensee	22. Name and Address of Facility Tarring-Cargo Fune	2 **	20	
Physician	\dashv	23a. Part I. Enter the disease, or complications that caused the death. Do no	Tarring—Cargo_Fune tenter the mode of dying, such as cardiac of	ral Home, or respiratory arrest	, P.A. Abe:	Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerotic	Cardiovascular Disease			Between Onset and Death
aminer		or condition resulting in death) Due to (or as a consequence of):	81 .			
	ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				ļ.,,
and and - transit		events resulting in death) Last Due to (or as a consequence or):				
'60, cate be execut	Medical	UNPENDED AMENDED				
3760, ficate b		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth	Fetal death 3 Ectopic pregn	ancy	23d. Date of deliver	y Day Year
Box 687 e death certific the attending I ed for use as the	sician	past 12 months? 4 Pregnant at time of death			I WOTHER	ou, roui
D. Bo) trithe death by the att	Phys	1 Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I	23e Did tob	acco use contribute to	the cause of death?
P.O.		Morbid Obesity	The the one crying cause given in Fart I.			pably 4 Unknown
ords, P.C. w requires that as been signed to should be deta	Completed by			24a. Was an		stopsy findings available completion of cause of
Reco The law icate has	duc			perform	ed? death?	
tal Recions: The scertificate	Be C	25. Was case referred to medical examiner?	26.Place of Death (Check	only one)		
Division of Vital Records, tal or Attending Physician: The law requir rs after death. al Director: After this certificate has been sted in by the funeral director, page 2 should I	2	1 ✓ Yes 2 No Inspiral 1 Inpatient 2 ER/O	utpatient 3 DOA Other Nursi		esidence 6 Othe	r: Scene
on of nding Pl th. r: After re funera	ion:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	1 Yes 2 No	26d. Describe no	w injury occurred	
r Atter	ficat	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, fa	rm, street, factory, office building, etc.			ural Route Number, City
Divisior Bospital or Attend 24 hours after death Finneral Director:	Certification:	4 Homicide determined (Specify)		or Town, Sta	te)	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tra	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea Medical Examiner: On the basis of examination and/or in an amanner stated.				
F 3 F 8	Me	29b. Signature and title oil certifier	29c. License number		29d. Date signed (Mo	nth, Day, Year)
		AIVV ()	O.C.M.E.		June 25, 2007	
13x1		30. Name and address of person who completed cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 1	11 Penn Street, Baltimore, MD 2	1201		
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signatute	docale			
Regist	rar	JUN 2 8 2007 Librer D. ,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician Month 1) arg 5:24 PM aret 2007 June 23 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Maryland NIA Baltimore Iniversity Medical Certa | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Sept | 3 | 959 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔀 F 47 Pennsylvania 135-40-3658 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 XYes 2 □ No MD Queen Anne's Director Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Holly St. 21617 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 X No White Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed Is marked other than "naturaumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Branch Manager Bank 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas J. Arkinson, Jr. Margaret Prellwitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Mark A. Fuller (husband) 301 Holly St. Centreville, MD. 21617 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 6/26/07 Kent Cremation Smyrna, DE. 5 ☐ Other (Specify) 21. Signature of F ervice Lic Galena Funeral 118 West Cross Home of Stephen St. Galena, MD. M00510 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or hear Immediate Cause Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by nasarca 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: 20 No 1 ☐ Yes Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No neral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled in 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) rasto us

DHMH 17 Rev 1/2001

10

State Registrar Michael

31. Date filed (Month, Day, Year)

ORIGINAL

Greene Street

225

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GRASSO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	aryland	-	artmeni rtificate					jiene og. No	007	20932
	Dhamini		1. Decedent's Name (First, Middle	, Last)				-			2. Date of Dea Month	th Day	Yeer	3. Time of Death
	Physicia /Medic	_	JOHNNY	FAUL	KNER						JUNE	11,	2007	6:25P M
	Examin	er	4a. Facility Name (If not institution						Location of				County of Death	
			FORT WASHINGTO 5. Social Security Number		ENTER e (In yrs. las	et hirthday)	FO If Under		ASHIN If Under		8. Date of Birth		RINCE G	EORGES
	Funeral Director		239 50 4791	XXM 2□F	67	Yrs.	Months	Days	Hours	Min.	OCT . 07	Year)	Cour	H CAROLINA
-			Usual Residence of Decedent			····	1				0011 07	, .,		
	show	L.	10a. State 10b. County		10c. City,	Town or Lo	ocation						1	0d. Inside City Limits 1 ☐ Yes 又 No
	Ba-f	Director		E GEORGES	FOR'	T WAS	HINGT					0- 04-		
:	death with the Maryland ms 23a or 28a-f show rmust be redified at	Ē	10e. Street and Number	ATTENTED			10f. Zip						en of What Cour	. —
	eath rs 23	Funerai	1729 RHODESIA 11. Marital Status	AVENUE 12. Was Decedent	Ever in U.S.	13.		0744		gin? (Spe	ecify Yes or No-		ITED ST 4. Race - Americ	
	rter d	Ē	1 Never Married 2 Marr	Armed Forces? ied 1 ☐ Yes ※※ I		1				i, Puerto	ecify Yes or No- Rican, etc.)		Black, White,	
2-003p	hours after tural', or Ite al Evalmine	ğ	XX Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes X	X_ No	Specify:				Specify: BL	ACK
'n	2 e 3	Completed	15. Deceden (Specify only highe	t's Education st grade completed)		(Give	dent's Usua kind of wor	rk done a	turing mos	t of worki	ng	16b. Kind	d of Business/In	dustry
2	within ene. than "	mp	Elementary/Secondary (0-12)	College (1-4or 5			DO NOT us			п <i>с</i> тът	OTAL TOP		DEDAT O	OHEDMENT
N	be filed vital Hygie od other l	င္ပ	12 TH 17. Father's Name (First, Middle,	Last)		PROPE	KIY M	ANAG			CTALISI (First, Middle,			OVERNMENT
⊆ .	a la b	To Be	MACK FAULKNER						AT.BT	ZRTA	REID			
	should ind Men marke umatic	-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address	(Street a				r, City or	Town, State, Zip	Code)
Z .	s 1 and 2 should f Health and Mer item 27 is merke other traumatic		ROBIN WILLIAMS	/ DAUGHTER		1729	RHODE	SIA	AVE.	FOF	RT WASHI	NGTO	N, MD 2	0744
ம	of He of He fiterr		20a. Method of Disposition XIX Burial 2 ☐ Cremation	3 □Removal from State	20b. Plac	ce of Disponetery, crea	osition (Nan matory or o	ne of ther plac	e)		Date	20c. Loc	ation - City or To	own, State
ē	Pages tment of I tant: If it tjury or o		`4 □ Donation 5 □ Other (S		RESU	JRREC'	TION (CEME	TERY	06/1	8/2007	CL	INTON, N	ſD
gall	permit. Pag Department Important: any injury o		21. Signature of Fune al Service	Nousll		M	2. Name an ARSHA 308 S	LL'S	FUNE	ERAL	HOME OF	MAR	YLAND, I MD 2074	NC.
			23a. Part. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	d the death. ne.	Do not en	ter the mod	e of dying						Approximate Interval Between Onset and Death
Ŧ	hysician		Immediate Cause (Final disease or condition	- a Ather	oscle	notic	Cor	ohar	y A	r ter	y Di	Seas	ze	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):			J					
		ē	Sequentially list conditions, if any, leading to immediate	b. Dea to for se	a conseque	nee ofk								
	uted Insit	m Lin	Cause (Disease or injury	\		,								
,	s be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	C. Due to (or as	a conseque	nce of):								
760,	ite be ex iysician ne buria	icai		d										
B G		Med	IF FEMALE:											
X P Q	leath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1⊟Live birth	2 Fetal d	eath 3	⊒Ectopic pr					23	3d. Date of delive Month	ory Day Year
5	at the dea by the a stached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant a 9∐Unknown	t time of dea	th 5L	Other (sp	ecify)						
7.	that the	H.	Part II. Other significant condition	ons contributing to death b	ut not result	ing in the u	inderlying c	ause give	en in Part I		23e. Did to	bacc <i>o</i> us	e contribute to t	ne cause of death?
g	urres tha signed id be det	d by	Hypertensi	ØN							1 X Y	es 2□]No 3□Prob	ably 4 Unknown
ecords	law requires that the as been signed by th 2 should be detache	Completed	Emphysema								24a. Was a		24b. Were auto	psy findings available
ğ	o − 6	E O	11	mia							autops perfor 1 Yes	med? 2 No	death?	mpletion of cause of 2□ No
	sician: The certificate irector, pag	Be C	25. Was ca referre to dica examiner?						26. Place	of Death	(Check only or			
> to	8 .≘ . 5	5	1X Yes 2 No	Hospital: 1 Inpatie		R/Outpatie		_	4 140	rsing Ho	me 5 Resid	ence 6	□Other (Specif	y)
	gr and	Ë	27. Manner of Death 1 Natural 5 ☐ Pendir	28a. Date of Inju (Month, Da	iry 2 iy Ye <i>ar)</i> 2	8b. Time a Injury		8c. Injury Work			28d. Describe h	ow injury	occurred	
<u>s</u>	Attending r death. ector: After by the fune	cati	2 Accident investi 3 Suicide 6 Could	not be one Blood of Ini	iune. At hom	o form at	M factor	-	Yes 2□		28f Location /S	troot and	Number or Burs	al Route Number,
=	i Diffe	Certification;	4 Homicide determ	28e. Place of In building, et	ic. (Specify)	ie, iaiiii, st	reet, ractory	r, onice			City or Tow		Transpor or Trans	r rioute reunion,
_	Hospital 24 hours a Funeral I tely filled		29a. Certifier 1 Certifyin	ng Physician: To the best	of my knowl	edge, deat	h occurred	at the tim	ne, date an	nd place,	and due to the c	ause(s) a	and manner as s	tated.
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical one)	Examiner: On the basis of and manner st		n and/or in	vestigation	, in my op	pinion, dea	th occurr	ed at the time, o	late and p	place, and due to	the cause(s)
	To the Hi within 24 To the Fi complete	M	29b. Signature and title of portific	1///					number	1			signed (Month,	
			1 100		MI)	1	146	741			June	e II,	2007
) `	(4)		30. Name and address of person		death (Item 2									
				CH DEVH	MIV:		1701	LIVI	NGSTO	ON RO	DAD FOR	T WA	SHINGTO	N,MD 20744
	Sta Registi		31. Date filed (Month, Day, Year, JUN 1 4 2007	Seren D	rar's Sign	A)								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Rea. No. 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death 09,2007 Month **Physician** June 8:07 Glorine Foale /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George Future Care Nursing Facility Clinton | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 8 / 1 9 / 0 8 / 1 9 / 1 | 9. Birthplace (State or Foreign Country)
South Carol 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□ M 2 🗗 F Director 577-30-8862 Usual Residence of Decedent the Maryland 10c. City Town or Location 10d. Inside City Limits 10a State 7 is marked other then "naturel", or Items 23a or 28a-f shov treumatic event, the Medical Examinar must be notified at 1 ☐Yes 2 ☐ No Temple Hills Prince George Director Md 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 20748 IISA 4109 Rocky Mount Drive death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. If them 27 is marked other then "naturel", or Item any injury or other treumetic event 1 □ Never Married 2 □ Married Specify: Black Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: lf Yes, Give Year or Dates: þ 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

COOK Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Private Industry Elementary/Secondary (0-12) 6th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Green Samuel Sumpter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Williams(Daughter)4109 Rocky Mount Dr. Temple Hills 20748 Catherine 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Island Cemetery Santee South 06/16/07 21. Signat of Funeral Service Licen 22. Name and Address of Facility Tyrone J. Young 719 Kennedy St.Wash DC mplications that caused the doaln. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. 23a. Part 1 Enter the disease, or co shock, or heart failure. List of Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Arteriosclerotic Cardiovascular Disease Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 XNo 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown ate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2X No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 XNursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospitel within 24 hours are To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 12th 2007 D-18545 dress of person who completed cause of death (Ite 231) (Type, Print) Philip Wisotsky M.D. 12070 Old Line Center Waldorf, Md 20602 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 3 2007 Registrar

HRAMPTON, Cecelle Baltimore, Maryland 21215-0036

Examiner sician and burial-transit

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Cecelia Hubba<u>rd Frampton</u> 2007 UNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AL HOSPITA ASTON MEMORIAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov. 25, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 5. Social Security Number **Funeral** Days 1 □ M 2 🗓 F 219-07-6204 93 1913 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits if Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐No Director MDCaroline Denton 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9616 Corkell Road 21629 United States Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify White þ Specify: 3x Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the M Seamstress Sewing Factory (Grad. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Viola Wright Arthur Hubbard 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Corkell/Sister 9616 Corkell Road, Denton, MD 21629 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Hillcrest Cemetery 06/22/07 Federalsburg, 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Urinary Tract Infection **Physician** disease or condition resulting in death) mplicated /Medical Dualo (or as a consequence of): Sequentially first or differs if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4⊡Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 I Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown cate has been significant page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of persor who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Pichard Griffiths
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 3. Time of Death Decedent's Name (First, Middle,Last) Physician/ Month 2234 hrs Richard Griffiths June 10, 2007 Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Fort Washington 8155 Murray Hill Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Country Panama Davs Aug. 16, 1929 77 264-66-3552 Director XX M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Yes 2XX No 28a-f show Maryland Prince George's Ft. Washington it. Pages I and 2 should be filted within 72 hours after death with the Maryland transit of Health and Mental Hygiene. Transit: If liten 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar more to. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8155 Murray Hill Drive 20744 USA 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? Never Married 2 Married 2 XX No Yes 1 XX Yes 2 No specify: Panamanian Black. Specify: 4 X Divorced If Yes, Give Year Widowed ð 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Marshall Federal Government 21215-0036 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruby Genius Richard Alejandro Griffiths. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) MD. 302 Everleigh Court Marietta, Georgia Pablo A. Griffiths / Son 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Saltimore, crematory or other place) 1 Burial 2 XXCremation 3 Removal from State 06/13/2007 Kalas Crematory Edgewater, Maryland Department of Donation 5 Other Specify 22. Name and Address of Facility George P. Kalas Funeral Home PA 21. Signature of Funeral Service Licensee 6160 Oxon Hill Road Oxon Hill, Maryland Kales Approximate Interval 23 Vart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line Death 'Medical a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine Lause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed the attending physician and led for use as the burial - tran Physician/Medical AMENDED UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Fetal death Live birth past 12 months Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. No 3 Probably 4 V Unknown þ Yes 2 Completed ficate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? certificate has No ✓ Yes 2 No 1 🗸 26.Place of Death (Check only one) To the Hospital or Attending Physician: 'within 24 hours after death.'
To the Funeral Director: After this certifi 25. Was case referred to medica funeral director, Other₄ Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene DOA 2 ER/Outpatient 3 Inpatient 1 V Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 1 V Natural Yes 2 5 Pending the 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc pletely filled in by Could not be 3 or Town, State) Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title June 11, 2007 O.C.M.E. leted cause of death (Item 23a) 30. Name and address of person who co

State Registrar Susan Hogan MD.

Assistant Medical Examiner

32. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (... 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2007 **Physician** SIXTO JAVIER RIOS GARCIA JUNE 11 3:25 P M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY NATIONAL INSTITUTES ΟF HEALTH BETHESDA If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months 1X M 2 □ F 583-29-6618 Director May 3, 1974 Puerto Rico Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Yes 2 No Director Adjuntas PR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 00601 HC02 Box 6157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1X Yes 2□ No Specify: ş 3 Widowed 4 Divorced Puerto Rican Hispanic Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Disabled None 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jose Ramon Rios Quinones Maria Isabel Garcia Lopez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 00601 Maribel Rivera Sotomayor/Wife HC02 Box 6157 Adjuntas, PR. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-16-2007 Luz Del Gigante Adjuntas, PR 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 4217 9th St. N.W. Washington, D.C. 20011 23a. Part1. Eyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 075 tailvie Pes Diration /Medical Due lo (or as a consequence of): Examiner Yeas Horal Carring Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Honknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed?
Yes 2 No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 N 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred (Month, Day Year) Injury 1 ☑ Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the death certificate be executed P.O. Box 68760

the attending physician and hed for use as the burial-tran

with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

should be detached signed by Division or Vital Records, been cate has page 2 s To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica

MAURO SARMIENTO

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

29c. License number

🚄 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

MA 226573

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

JUNG 11, 200'

30. Name and iddress of pers in who completed cause of death (Item 23a) (Type, Print)

10 CENTER DRIVE, BETHESDA, MD 20892

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Sigral JUN 1 3 2007

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 11, HORN JUNE 2007 12:25 AM GERTRUDE LILLIAN 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death ALLEGANY COUNTY NURSING HOME CUMBERLAND ALLEGANY If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 WEST VIRGINIA 8. Date of Birth (Month, Day, Yeer) JAN. 26,1925 7. Age (In yrs. last birthday) 5. Social Security Number Days Hours 1□ M 2X F 82 215-22-0709 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No WV MINERAL RIDGELEY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 26753 U.S.A. ROUTE 3, BOX 26 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 21 No If Yes, Give 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🛣 No Specify: Specity: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 HOMEMAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BESSIE CLINE BENJAMIN HARRISON MYERS 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ROUTE 3, BOX 26, RIDGELEY, WV 26753 JAMES E. HORN / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State RESTLAWN MEML. GARDENS 4 ☐ Donation 5 ☐ Other (Specify) 06/14/2007 LAVALE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. calle 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 25 No 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2□ No 1 Yes 2X No 1 Tes 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigetion 2 ☐ Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner UIVISION Of Vital Records, P.O. Box 68760, of order death certificate be assecuted effect death. burial-transit end ettending physician for use es the buria within 24 hours efter death.

To the Funeral Director: After this certificate has been si completely fillad in by the funeral director, page 2 should

Be Completed by Physician/Medical Examiner

Physician /Medical

Physician

/Medical

Examiner

Funeral Director

Be Completed by

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If flem 27 is merked other than "natural", or hame 22----- any injury or other traumeth.

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 25. Was case referred to medical examiner? 27. Menner of Death Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier

29c. License number

Eumber land

29d. Date signed (Month, Day, Year)

10

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

A Rangthan, MB 51 E. Old town

State Registrar

Medical Certification: To

29b. Signature end title of certifier

32) Registrer's Signature 31. Dete filed (Month, Day, Year) JUN28

To the Hospital c within 24 hours of To the Funeral Di

		•	For State Registrar	State	of Maryla		irtment of tificate o		nd Me		giene	07	2093)
H	Physici	an	Decedent's Name (First, Middle							Jun 24,	Day 7	Year	3. Time of Death
	/Medic	al	William 4a. Facility Name (If not institution	Junior		etrick	4h City Town	n, or Location of		Jun 24,	4c. County	of Death	35 M
	Examin	er	Allegany Co. Nu	-		r.	Cumbe		Death		Allega		
	Funeral Director		5. Social Security Number 722-12-3328	6. Sex 1X M 2□ F		. last birthday) Yrs.	If Under 1 Year Months Day		24 Hrs. Min.	8. Date of Birth Jun 14,	1925	9. Birthplac Country	e (State or Foreign
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. C	ity, Town or Lo	_					10d.	. Inside City Limits
	e-f sh	ctor	MD Alle	gany		Spring	g Gap						1 ☐ Yes 2 ☐ No
	with th	Director	10e. Street and Number				10f. Zip Code	21560			10g. Citizen of V	,	?
	ns 234	Funeral	Box 67	12. Was De	ecedent Ever in I	J.S. 13. V	Vas Decedent of Yes, specify C		jin? (Spec	cify Yes or No-		e - American	
036	filed within 72 hours after death with the Maryland Hygione. the than "natural", or Itams 23a or 28e-f show ant, the Mazical Exacitrational be incilled at	þ	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 🔏 ☐ Divorced	ried 1 Yes	Forces? s 2 □ No Give WWI Dates: WWI		Yes, specify C		, Puerto F	Rican, etc.)		ck, White, etc white	:.
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מפר		BeC	17. Father's Name (First, Middle,			0.4	<u> </u>	18. Mother		(First, Middle,	Maiden Sumam	18)	
<u>Y</u> a	should be filed within 72 ho nd Mental Hygiene. I marked other than "natur umatic event, the Mudical.	To	William Hetric				land as) Hetricl		
Baltımore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Importent: If item 27 Is marke any injury or other traumatic ones.		19a. Informant's Name/Relations Junior Hetrick		on	P.O. I	g Address (Stre Box 101	eet and Number	r or Hurai	Oldtov	r, City or Town, VN	MD 2	21555
J.	of Hea of Hea fitem		20a. Method of Disposition	2 🗆 🗆		Place of Dispo cemetery, cren	sition (Name of natory or other p	olace)		ate	20c. Location -	City or Town	n, State
Ĕ	. Pages tment of I tent: If it jury or o		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (5	pecity)	Ro		/eterans (/26/2007	Flintsto	ne	MD
Bal	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service	Licensee	1/1/	/ 22	Name and Add						
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Vital Record	The ate h page	Completed		\$*-\$****						24a. Was a autop: perfor	sy med?	Were autopsy prior to comp death?	y findings available letion of cause of ☐ No
VIta	Physician: this certific ral director,	Be	25. Was case referred to medica examiner?	Hospital:				Othor		(Check only or	ne)		
ō	this ald	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Da	te of Injury	28b. Time of	28c. In	njury at			ence 6 Oth		
ion	anding sath. or: Afte he fun	atio	1. Natural 5 Pendir Pendir Pendir	gation	onth, Day Year)	Injury		Vork? ☐Yes 2☐N	40				
Division	s after de s after de al Directo	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	inod 288. Fla	ce of Injury - At I Iding, etc. (Spec	home, farm, str ify)	eet, factory, office	се	2	8f. Location (S City or Tow	itreet and Numb n, State)	er or Rural R	loute Number,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	edical (29a. Certifier 1 Certifyin (Check only one) Medical	ng Physicien: To t Examiner: On the and ma	he best of my kr basis of examin anner stated.	nowledge, death nation and/or inv	occurred at the restigation, in m	time, date and y opinion, deat	d place, a h occurre	nd due to the o	ause(s) and ma date and place, a	inner as state and due to th	ed. e cause(s)
	To t withi To tl	Ž	29b. Signature and title of curtifie	1				ense number	20		29d. Date signed	(Month, Da	y, Year)
			70 Name and addition	The same late of	uses of density fire	m 22a) /7:		20033	-8		June	24,	
	1		30. Name and address of person SUNIL GUP	TA, M.	D. 602	SKE	NTAV	E. Cui	MBI	PLAN	D, MD	215	02
	Sta Registr		31. Date filed (Month, Day, Year, JUN 2 8	2007	Registrar's Sign	ature Gos	W						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death 9:00 A. June 8, 2007 s. Hill 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 913 Waterford Road Montgomery Silver Spring | Months | Days | Hours | Min. | March | Day | 1929 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2**X** F 78 196-18-3099 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYes 2 No Maryland | Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20907 913 Waterford Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Professional Nurse Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edwin D. Snider Marcle R. Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lisa C. Hill/Daughter 100 Arden St. #6G New York, NY 10040 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Geo. Wash. University June 8 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2007 Washington, D.C. 4X Donation 5 ☐ Other (Specify) Medical Center 22. Name and Address of FacilityColumbia Mortuary Services 21. Signature of Funeral Service Licensee 9013 Annapolis Rd. Lanham, MD 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ears Due to (or as a consequence of) Disk to for as a parasemente offi Due to (or as a consequence of): If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 Fetal death Year Month Day 5 ☐ Other (specify) 9☐Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an was ... autopsy performed? 1 Yes

Physician /Medical **Examiner**

ending physician and use as the burial-transit

Physician

/Medical

10a. State

Director

Be Completed by Funeral

Examiner

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once.

Be Completed by Physician/Medical Examiner Medical Certification: To

Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 1 ☐ Yes 2 ② No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760, Division or Vital within 24 hours after death

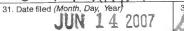
To the Funeral Director:
completely filled in by the

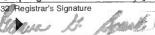
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MILMODZIN 5454 AVENUE #1300 CHEVYCHASE, MD 20815 Kalil

State Registrar





			For State Registrar	State	of Marylar		artment of I rtificate of	Health and Death	Mental Hy	giene, Reg. No.	2007	201	940
'n	*		Decedent's Name (First, Midd	lle, Last)					2. Date of De Month	eathDay	Vear	3. Time of	Death
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	Examin	- 2	4a. Facility Name (If not institution	_				or Location of Deat	th	4c. (County of Death		
			FREDERICK ME 5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	FRED.	ERICK If Under 24 Hrs	8. Date of Bi	rth	FREDERI 9 Birthi	Diace (State o	r Foreian
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	he Ma 8a-f s	Director		tgomery		Germ	nantown 10f. Zip Code			10- Citi-	en of What Cou		
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12-0036	72 hours after natural", or ite dical Examine	d b	3 ☐ Widowed 4 ☐ Divorce	d Year or	Dates:				Vadoran				
<u>7</u>	"natu	lete	15. Decede (Specify only high	nt's Education est grade complete	d)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	orking	16b. Kin	d of Business/In	dustry	
7	within iene. than " the Mec	Completed	Elementary/Secondary (0-12)	College	e (1-4or 5+)		one	.4)		N/A			
N O	Hygir Hygir Sther ent, II	യ	17. Father's Name (First, Middle	, Last)	<u>. </u>			18. Mother's Na	me (First, Middle	1 '	Surname)		
land	should be f and Mental I s marked of umatic eve	To B	Julio Tobar					Tati	ana Heri	nande	z		
Mary	2 should be filed v n and Mental Hygie 'Is marked other t raumatic event, th		19a. Informant's Name/Relation					t and Number or R					
	and 2 eaith a n 27 is		Julio Tobar/F	ather ————				Drive, #	<u> </u>		<u> </u>		
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E	t. Partmen rtmen rtant:		4 Donation 5 Other (Ga		Heaven Ce		2007	Silv	er Sprin	ng, Mary	rland
ga	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service	c C	6	Î	rancis o	ess of Facility J. Collinersity Bl	s Funera	al Ho	me Inc.	na MD	20901
r			23a. Part1. Enter the disease,	or complications that	at caused the dea						CI SPIII	Approximat Interval Bet	е
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	/Medical		disease or condition resulting in death)		to (or as a conse	Andrew Control of the	74 2100	ioks gest	100, 10	20,000	weight		
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_	and I-trans	Examiner	that initiated events resulting in death) Last	c	to (or as a conse	quence of):							
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289	ficate g phys	edical	******	0									
Ř	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant		outcome pf pregr		⊒Ectopic pregnan	cv		2	3d. Date of deliv		.,
	e deat he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pre	egnant at time of		Other (specify)				Month	Day	Year
J O	w requires that the d been signed by the should be detached	Phy	9 ☐ Unknown Part II. Other significant condi			eculting in the u	inderlying cause a	iven in Part I	23e Did	tobaccour	se contribute to	the cause of	leath?
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Vital			25. Was case referred to medic	al				26. Place of De	1 Yes eath (Check only		1 ☐ Yes	2∐ No	
	ysicia is cert direct	To Be	examiner? 1 ☐ Yes 2 📉 No	Hospital:	NInpatient 2	☐ ER/Outpatie	nt 3 DOA	thor:	Home 5 ☐ Res		i □Other (Spec	ify)	
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Division or	or Att fter de Direct	Certification:		minod 200, File	ace of injury - At l uilding, etc. (Spec	home, farm, st cify)	reet, factory, office		28f. Location City or To	(Street and own, State)	d Number or Rui)	al Route Nun	nber,
	pital ours al		29a. Certifier 1 Certify	Ing Physician: To	the hest of my kr	nowledge dea	th occurred at the	time date and place	ce and due to th	e cause(s)	and manner as	stated.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical		al Examiner: On th									s)
	To the within 2 To the complet	Me	29b. Signature and title of certif	ier	20		29c. Licer	ise number		29d. Dat	e signed (Month	, Day, Year)	
)			Maulon	de Ma	lla		D	35141			6/12/	07	
			30. Name and address of person	n who completed c	ause of death (Ite	em 23a) (Type	, Print) May	ilea K	Mille	V, N	10		
			Frederick Memory	rial Hos	pital	, 400 L	U. 7th	t. Fre	devick	, Mo	(21701		
	Sta Regist		31. Date filed (Month, Day, Yea	4 2007	Registrar's Sign	nature	ments.						
	riegist	a.	GUIL 7			1.1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 10 2007 2:16 A David Livingston Haynie /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Annapolis Anne Arundel Medical Center Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) **Funeral** Days Year 1 XM 2□ F 87 Aug. 14, 1919 S. Carolina 247-18-4456 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director Bowie MD Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12608 Crimson Court 20715 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify White þ 3 Widowed 4 Divorced Year or Dates: WW II Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Owner Furniture Retail 12 marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be fi th and Mental F. 7 is marked oth Be Mary M. Campbell Francis W. Haynie 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) , 1 and 2 st of Health ar fitem 27 if or other tr MD. Betty P. Haynie / spouse 12608 Crimson Court Bowie, 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any injury or oth 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Mem. Gardens 06/13/2007 Davidsonville, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licen Beall Funeral Home 6512 NW Crain Hwy. owe Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed the burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9∏Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? tate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Noknown NOUS Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 ☐ No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the

State Registrar

31. Date filed (Month, Day, Year)

MOTCHILL

29b. Signature and title of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D39037

AAML 2001 MEDICAL PARKWY ANDAPOUS MO

29d. Date signed (Month, Day, Year)

06-10-07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last, 3. Time of Death Month **Physician** 04:40A^M Lillie Mae Jennings 2007 10, <u>June</u> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford 7. Age (In yrs. last birthday) Funeral Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 X F 66Yrs. Director 213-38-5059 Oct. 17, 1940 Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-f ehov other traumatic event, the Medical Exampler must be notified at 1 X Yes 2 ☐ No Director Maryland Harford Havre de Grace with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 **Нета 23** 720 Erie Street 21078 U.S.A. Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal. Department of Health and Mental Hygiene. Importent: if Item 27 ie marked other than any injury or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2X Married Specify: White 1 ☐ Yes 2 🗷 No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ Frank Henderson Fonti Hanna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ttingham Cem. 6/14/2007 Colora, Maryland
22. Name and Address of Facility Zellman Mitchell Smith Funeral Hom West Nottingham Cem. 6/14/2007 21. Signature of Funeral Service Licensee 123 S. Washington St. Havre de Grace, MD 21078 cott-colonier 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Failure ore day /Medical Due to (or as a consequence of): Examiner Chrunic obstructive rulnumen disease exacematur Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 25 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1□ Yes 1 🗌 Yes : After this certification funeral director. 25. Was case referred to medical Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28 ER/Outpatient Medical Certification; To 1 ☐ Yes 3 No 1 Inpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation within 24 hours after death To the Funerel Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) halle, m 0000 4805 O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 South Parke Street #400 Aberdeen MO 21001 Prashant Shukla MD 31. Date filed (Month, Day, Year) 32. P gistrar's Signature State

Registrar

JUN 1 4 2007

lease Type or Print in Black Indelible Ink	. Ensure All Copies Are Legible
State of Maryland / Department of I	Health and Mental Hygiene

			for State Registrar	State of	iviai ylailu /		rtificate of			Reg. No.	007	20943
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6	/Medi	cal	Jennie 4a. Facility Name (If not institutio	n also atract and numb	Kraus		4h City Town or	Location of Death	June 2		ty of Death	0905 а м
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	Funeral		5. Social Security Number		Age (In yrs. last I		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day Sep 8,			place (State or Foreign ntry)
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	ath with the 23a or 2 ust be no	ral Dire	3836 Amesbury					7 55			S.A.	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Extrainer must be notified at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ X Widowed 4 □ Divorced	If Yes Give	es? X No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 █ No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Ra Bi	ace - Ameriack, White,	
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Baltimore, Maryland	Pages 1 ment of H tant: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☑Cremation 4 ☐ Donation 5 ☐ Other (5	Specify)	ate Smith	ısbu		ory Jun 2			sburg	own, State ,Maryland
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Funeral Director

		For State Registrar			State o	of Marylan		oartmen e <i>rtificat</i> e				/lental		ene	117	2091	400
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uneral irector		5. Social Security No. 577-26-63		6. Se	х]м 2 Х]F	7. Age (In yrs. 8:		Months	Days	If Under Hours	Min.	8. Date of (Mont) Jan.	h. Dav.)	^{'ea} r) 1924	Coul	place (State or Foreign ntry) hington,DC	
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Division or Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and

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			For State Registrar		State of	t Ma	ryland /	•	irtment <i>tificate</i>		Health and N <i>Death</i>	,	giene Reg. No.			
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	/Medic		4a. Facility Name (If not	t institution, giv	e street and nur						r Location of Death	00		ounty of D		1933
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	neral ector		 Social Security Number 168–22–3510 	1	ex Mim 2□F	7. Age	(In yrs. last b	irthday). Yrs.	If Under 1 Months	Days	Hours Min.	8. Date of Bir (Month, Da April	y, Year)		Count	lace (State or Foreign PA
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5-UU36 72 hours after death with the Maryland	: If them 27 is marked other than "naturar", or frems 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	/ Funeral	11. Marital Status 1 □ Never Married		12. Was Dece Armed Fo 1 XYes If Yes, Giv	rces? 2 ☐ No	ver in U.S.		Vas Decede f Yes, specit □ Yes 2		lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		. Race - A Black, V pecify:		
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within 72 iene.	Medic	Completed	(Specify of Elementary/Seconda	only highest gra	College (1	-4or 5+					during most of work d)	ing				
filed with	t, the	Com			2		, E	lect	rical	En	gineer	*****		hine	Со	•
land Z	ed oth	Be	17. Father's Name (Firs	·)						18. Mother's Nam Marie E		, Maiden Si	ırname)		
1arylan 2 should be 1 and Menta	mark	욘	Fred_Kubli, 19a. Informant's Name		Type. Print)		19	b. Mailin	g Address (Street	and Number or Rui		er, City or 1	own, Sta	te, Zip	Code)
e, Me 1 and 2 Health a	ertrau		Doris A. Ku	bli/Wif	:e		7	64 W	hite (Oak	Dr., Swa	nton, M	ID 21	561		
More Pages 1 and the ment of He	Important: If Item 2 any injury or other once.		20a. Method of Disposit		Removal from	State	20b. Place of cemete	of Dispos ery, cren	sition (Name natory or oth	e of her plac	ns ial _{June}	Date	20c. Loca	tion - City	or To	wn, State
baltimo permit. Page Department	Injury		4 ☐ Donation 5 ☐ 21. Signature of Fune		* *		Garre	tt C	lo. Mei	Mor	ial June	23,200	7 Oak	land	, M	aryland
Dep m	au au		122	un	eum	au)				neral Hom	nes, P.A	A., Gr	ants	vil	le, MD 21536
Dhue	ialan		23a. Part1. Enter me shock, or heart a Immediate Cause (Fina	ilure. List only	plications that c one cause on e	aused t ach line	he death. Do	not ente	er the mode	of dyir	ng, such as cardiac	or respiratory a	rrest,			Approximate Interval Between Onset and Death
	dical		disease or condition resulting in death)		a. Due to (or as a	consequence	of):		~	propose	4-			-	2 hours
Exan	niner	er	Sequentially list conditi if any, leading to imme- cause. Enter Underlyin	ions, diate	b. Due to	0 51 or as a	consequence	of):	Hem	OR	RhAge	•		-	+	
ecuted	and -transit	Examiner	cause. Enter Underlyin Cause (Disease or inju- that initiated events resulting in death) Last	ry	c. Due to	7.1	consequence	TRR	mio	~					_	
re be ex	ysician e burial	_	,	Į	d.	01 45 2	consequence	roij.								
c oo/	ing pri e as th	Medi	IF FEMALE:													
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after clearh.	rne arrend ned for us	Physician/Medica	23b. Was decedent pre in the past 12 mor 1 Yes 2 No 9 Unknown	nths?		irth 2 ant at ti	f pregnancy Fetal deat me of death		Ectopic pred Other (spec		у	-	23	d. Date of Month		ry Day Year
S that the	ned by e detacl	by Phy	Part II. Other significan	nt conditions	contributing to de	eath but	not resulting	in the un	iderlying cau	use giy	on in Part I.	23e. Did t	obacco use	contribut	e to the	e cause of death?
COLOS W requires	gen sig	ted b	H1517	1 dy i	1	rw	> M	wo	reard	ul	mparch	10	Yes 2	No 3[] Proba	ably 4 □Unknown
The law	are nas b page 2 sh	Completed	BRA	in 1	umor		Pro	MA	Te H	em	orehade	24a. Was auto perfo 1□ Yes		24b. Werd prior deat 1 □ `	to con h?	osy findings available npletion of cause of 2 No
VICAL Iclan:	ector,	Be (25. Was case referred examiner?	to medical	Hospital			, 16.4		Tour	26. Place of Deat					
Phys	ral dir	. To	1 Yes 2 No 27. Manner of Death			npatien		utpatient Time of	1 3 □ DOA	_	4 Li Nursing Ho	ome 5 Resi			Specify	")
ndlng rth.	e fune	ation		□ Pending investigation	28a. Date (Moni	th, Day	Year)	Injury	М	c. Injur Wor 1 🔲	k? Yes 2∐No	Edd. Deddilbe	now injury	occurred		
DIVIS al or Atter after dea	d in by th	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place	of injur	y - At home, f (Specify)	arm, stre	eet, factory,	office		28f. Location (City or To		Number o	r Rural	Route Number,
e Hospita 124 hours	e runera letely fille	Medical C	29a. Certifier 1 2 Check only one)	Certifying Ph Medical Exa	nysiclan: To the miner: On the ba	asis of e	examination a	je, death nd/or inv	occurred at estigation, i	t the ti	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) a date and p	nd manne lace, and	r as sta due to	ated. the cause(s)
To th	dwoo	Me	29b. Signature and title	of certifier	8.1	Ze.	he		29c.	Licens	e number 14214	.)	29d. Date	signed (M	21	Day, Year)
i	VA	<i>i</i> 5	30. Name and address	of person who	completed caus	e of dea	ath (Item 23a)	(Type, I	Print)	(um Be	erl and	1	M.	, ,	21502
	Sta	_	31. Date filed (Month, L			egistrar	's Signature		P 10				'/ '	-(
R	legistr	ar	Jl	JN 22	2007		no de	A.		-						

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [XNo If Yes, Give Year or Dates:

10d. Inside	
1 □Y	es 2X No
10g. Citizen of What Country?	

U.S.A.

Specify.

16b. Kind of Business/Industry

14. Bace - American Indian.

WHITE

Black, White, etc.

4c. County of Death

ALLEGANY

2007

3. Time of Death

Birthplace (State or Foreign Country)

WEST VIRGINIA

19:00 M

2. Date of Death

8. Date of Birth (Month, Day, Year)

MAY 29, 1922

JUNE

Day

9

Director 10e. Street and Number ROUTE 1 Funeral 11. Marital Status þ Completed Be

1 □ Never Married 2 □ Married

15. Decedent's Education (Specify only highest grade completed)

3 XWidowed 4 ☐ Divorced

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic eyent, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

physician and the burial-transit P.O. Box 68760, as use jo Division or Vital Records, page 2 s or Attending Physician:

(Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **EDUCATION** TEACHER 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH INSKEEP JOHN TWIGG 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26719 JOHN M. LLEWELLYN / SON P.O. BOX 275, FORT ASHBY, WV 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) SPRINGFIELD HILL CEM. 06/12/2007 SPRINGFIELD, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facil UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEAR LUNG CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🌠 No Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 | Yes 2 | No 3 | Probably 4 V Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 X No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ပ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office to ing, etc. (Specify) determined 4 ☐ Homicide 🗹 Certifying Phýsician: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JUNE 12, 2007 D36766 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 SETON DRIVE, CUMBERLAND, MD 21502 DR. VIK POONAI,

10f. Zip Code

1 ☐ Yes 2 🟋 No

16a. Decedent's Usual Occupation

26763

Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

Registrar

0

State

31. Date filed (Month, Day, Year)

JUN 2 8 2007

within 24 hours a To the Funeral I

2. Registrar's Signature

		•	For State Registrar	State of M	aryland		artment rtificate			and M		giene Reg. No.)07	20947
			1. Decedent's Name (First, Middle, I	Last)							2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physicia /Medic		William F	rancis Lee	, III						May	29	2007	8:50 A M
	Examin	_	4a. Facility Name (If not institution, g	give street and number	r)		4b. City,	Town, or	Location o	of Death		4c. Cou	nty of Death	1
			Prince Geor						heve					George's
	Funeral		Social Security Number 6	. Sex 7. A 1 ☑ M 2 ☐ F	lge (In yrs. las	t birthday) Yrs.	Months	1 Year Days	If Under:	Min.	8. Date of Birti (Month, Day	, Year)		nplace (State or Foreign untry)
	Director		212-27-5996	1200	24	115.					Feb. 7	1983	W	ash., DC
	and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Lo	cation							10d. Inside City Limits
	daryl f eho	5	M 1 1 D	01-				т	1. т	u = 1 1 .	~			1X□Yes 2□No
	28e-	ec l	Maryland Prince	George S			10f. Zip		ple I	1111		10g. Citizen	of What Co	untry?
	With Be or	፭	4514 Birch	tree Lane					20748	8		Un	ited	States
	ne 2:	Funeral Director	11. Marital Status	12. Was Deceden		13.	Was Deced	lent of Hi			ecify Yes or No- Rican, etc.)		ace - Ame	rican Indian,
9	or ite		1 Never Married 2 Married	Armed Forces			1 ⊟Yes 2				rsican, etc.)		Black, White A	frican
8	rel', c	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	i:		105	ZAJ INO	эрвопу.			396		merican
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene of other than "neturel", or lteme 23s or 28s-f ehow event, the Medical Examinat must be notified at	Completed by	15. Decedent's (Specify only highest			(Give	dent's Usua kind of wor	rk done d	luring mos	t of work	ng	16b. Kind o	f Business/	Industry
21	han han	ם	Elementary/Secondary (0-12)	College (1-4o	r 5+)	iire.	DO NOT us						16.5	1 1
2	filed w Hygies other t		12th 17. Father's Name (First, Middle, La	net)			En	tert	ainme		e (First, Middle,			mployed
anc	ntal h	Be	William Franc		•					-:		y Burn		
Maryland	2 should be filed withir and Mental Hygiene. is marked other than eumatic event, It e his	၉	19a. Informant's Name/Relationship			19b. Maili	na Address	(Street a	and Numbe	er or Rura	al Route Numbe			Zip Code)
Ma	d 2 s th an th an 17 is		Sydney A. Lee		- 1		•				Temple			20748
	Pages 1 and 2 ment of Health a ant: If Item 27 is ury or other tre		20a. Method of Disposition		20b. Plac	e of Dispo	osition (Nan	ne of	0)		Date	20c. Locatio	on - City or	Town, State
<u></u>	ages ant of t: If I		1 Surial 2 Cremation 3 4 Donation 5 Other (Spe		GP 7		ıln Ce		1	6///	2007	Br	en two	od, MD
Baltimore,	- モモラ .	- 1	21. Signature of Funeral Service Li		/ LC.		2. Name an				Stewart			
Ba	Depermine Depermine Important Important Inches	- 0) John T.	Stewart	III	1	4	001	Benn:		Rd., NE			
			23a. Part1./Enter the disease, or o	omplications that caus	ed the death.	Do not en	ter the mod	le of dyin	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between
	Physician		shock, or heart failure. List or Immediate Cause (Final				haada	Con	tuoi	222				Onset and Death
7	/Medical		disease or condition resulting in death)		bral Ho		nagic	COL	LUSIC	J11				
	Examiner			s Sku1	1 Frac	ture								
Н	_ ~	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		as a conseque							· -		
	cuted od ransi	Examiner	Cause (Disease or injury that initiated events		nonary		sion							
o,	e exe ien ar urial-t	EX	resulting in death) Last		as a conseque	,							1	
3760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	lcal	10	d. Moto	r Vehi	cle A	ccide	nt						
68	artifica ing pl	Physician/Med	IF FEMALE:	"	est transfer and									
Вох	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal d	eath 3	⊒Ectopic pr					23d.	Date of del Month	ivery Day Year
	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9☐Unknown	at time of dea	th 5	Other (sp	овсту) <u> </u>						
P.0	es that the death cer igned by the attendin be detached for use	Ph)	Part II. Other significant condition	s contributing to death	but not result	ing in the u	ınderivina c	ause div	en in Part I	 I.	23e. Did t	obacco use o	contribute to	the cause of death?
Js,	signe	by	Turk is a state of the state of	, , , , , , , , , , , , , , , , , , ,		•	,				10	res 2□N	o 3 ☐ Pr	obably 4 🔀 nknown
Records,	w requir been si should	Completed									24a. Was	20 2	th Were a	utopsy findings available
36	e law hes l	шb								_	autor		prior to death?	completion of cause of
al											1 ☐ Yes	2 No	1 🗌 Yes	2 □ No
Vital	Physician: The lav this certificete hes ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:	0 O E	D/Outpatio	- 2 D DC	Oth	00		h <i>(Ch</i> eckon <i>ly c</i> om e 5⊡ Resi		Other (Coe	out al
of	<u> 두</u> 등	5.70	1 X Yes 2 No 27. Manner of Death	28a. Date of I	njury 2	8b. Time o	of 3 DC	28c. Injun Wor	4 🗆 191	ursing no				control
Division	Attending Phyrideath. ector: After thi by the funeral	tlon	1 □Natural 5 □ Pending 2 ☒ Accident investiga		Day Year) 2007	Injury 015			k? Yes 2.5g7	No	DIIVe	r wno	Tost	COULTOI
isi	Attendii death. ctor: A y the fu	fica	3 Suicide 6 Could no	ot be 28e. Place of	Injury - At hom			y, office			28f. Location (Street and N	umber or Pu	ural Route Number
Š	after after Direct	Certification;	4 Homicide	building,	etc. (Specify)	Stre	et					d Sui		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	alc	29a. Certifier 1 ☐ Certifying	Physician: To the be	st of my knowl	ledge, dea	th occurred	at the tin	ne, date ar	nd place,	and due to the	cause(s) and	manner as	stated.
	ne Ho n 24 l ne Fu sletely	edical	(Check only 2 Medical E	xaminer: On the basis and manner	s of examination stated.	n and/or II	nvestigation	n, in my o	pinion, dea	ath occur	red at the time,			
	To the To the Comp	Σ	29b. Signature and title of certifier	11	4		29	c. Licens	e number			29d. Date si	gned (Mont	h, Day, Year)
			Salpeda	1/4/13	les D	5		Ho.	>55	92	7	Jus	7	2007
0	(10)		30. Name and address of person w	no completed cause of	of death (Item 2	23a) (Type	, Print)				/ "	1.	D	- 4
1	W		SALVADOR S	sylvater	300/	ths	, Ditzy	P	المراء		work	Me	ryla	78
1	Sta		31. Date filed (Month, Day, Year) JUN 1 4 2007	32. Regi	istrar's Signatu	3.1	7		,		01		tr.	
	Regist	ar	JUN 1 4 2007	Beleva	11. 19									

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

		1 - Registrar 6/25/07	AACO HEA				Pertificate of			g. No. 2 (10.7	20043
Physici	an	1. Decedent's Name (First, M	. ,						Date of Death Month		Year	3. Time of Death
/Medic		Joseph Ronald							6/	11/200		07:40a\m
Examin	er	4a. Facility Name (If not instit			,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	r Location of Death		4c. Count	ty of Death	1
1.000		Anne Arundel 5. Social Security Number	Medica 6. Sex			na biush	Annap		8. Date of Birth	Anne	Arui	
uneral		302-34-4293 Usual Residence of Deceder	1 🕅 N	1 -2 X F	Age (In yrs. It	Yr	Months Days	Hours Min.	11/16/1	938	Oh:	place (State or Foreign intry) 10
W +		10a. State 10b. Co			10c. City	, Town o	or Location					10d. Inside City Limits
f sho	jo	MD Ar	ne Aru	nde1		Gamb	rills					1 ☐ Yes 🔏 🙀 No
notif	Director	10e. Street and Number					10f. Zip Code		10	g. Citizen of	What Cou	intry?
s 23a oi nust be	eral D	2318 Maytime		Mr- Dd-	-1 Curs in 11 (<u> </u>	210			US		ican Indian,
Department or read and weather typerer. The protection of the part is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	d by Funeral	11. Marital Status 1 □ Never Married 2□ 3 □ Widowed 4550pivo	Married	. Was Decede Armed Force 1XX es 2[If Yes, Give Year or Dates	s? ⊒No 1	963 979	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 XX No	Specify:	Rican, etc.)		ack, White	
an "natu	Completed	15. Dece (Specify only h Elementary/Secondary (0-		tion completed) College (1-4d	or 5+)	()	ecedent's Usual Occup Give kind of work done ife. DO NOT use retire icer	during most of work	ing	6b. Kind of E		ndustry
it, the	ខ					011	icer	40.34-#		J.S. A		<u></u>
ever	B	17. Father's Name (First, Mic						18. Mother's Name	•		ime)	
nark	은	Joseph E. Hro		Brint)		10h B	failing Address (Street	Mary Jan			- Ct-t- 7	(- (0-4-)
7 Isr		Christina Lane		aughtei	^		41 London		vie, MD 2	-	n, State, Zi	p Code)
If item 2 or other		20a. Method of Disposition XXBurial 2 □Cremat			20b. Pl	ace of E	Disposition (Name of crematory or other pla	ce)	Date 2	0c. Location		
tant		4 □ Donation 5 □ Othe	er (Specify)		Che.	Lten	ham Vet Ce	i *				
Impor any In		21. Signature of Funeral Ser	vice Licensee	1			22. Name and Addres					, P.A.
/sician		23a. Part1. Enter the Iseas shock, or heart failure. Immediate Cause (Final disease or condition	e, or complica List only one a.	tions that caus cause on each	sed the death line.	. Do no						Approximate Interval Between Onset and Death
ledical aminer		resulting in death)		Due to (or	as a consequ	ence of)						
nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	₹	Due to (or	as a consequ	ence of)	:					
an and rial-tra		that initiated events resulting in death) Last	С	Due to (or	as a consequ	ence of)	:					
nysici he bu	ledical		d									
ng ph		IF FEMALE:										
To the Function area occurs. To the Function area occurs and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/N	23b. Was decedent pregnan in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	t 23c	. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknowr	2 ☐ Fetal at time of de	death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у			ate of deliv	very Day Year
signed to	by	Part II. Other significant cor	nditions contri	buting to death	but not resu	lting in t	he underlying cause giv	en în Part I.				the cause of death?
hould	ed											
page 2 s	Completed								24a. Was an autopsy perform 1 Yes 2		. Were aut prior to co death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
ertific ector,	Be (25. Was case referred to me examiner?					Tau	26. Place of Death	(Check only one)		
this o	ဥ	1 ☐ Yes 2 No	Hos	spital: Inpa		ER/Outp		4 LI Nursing Ho	me 5 Resider			ify)
r: After	tion:	27. Manner of Death 12 Natural 5 □ Pe 2 □ Accident inv	ending restigation	28a. Date of I (Month, I	njury Day Year)	28b. Tir Inji	ury Wor	ryat rk? Yes 2 ∐No	28d. Describe hov	v injury occu	ırred	
Directo	Certification:		ould not be termined		injury - At ho etc. (Specify		n, street, factory, office		28f. Location (Stre City or Town,	eet and Nun State)	nber or Rur	ral Route Number,
he Funera	Medical C	29a. Certifier (Check only one) 2 Med	tifying Physic lical Examine	ian: To the be r: On the basis and manner	s of examinat	vledge, o ion and/	death occurred at the ti or investigation, in my	me, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and n te and place	nanner as e, and due	stated. to the cause(s)
Tot	M	29b. Signature and title of ce	rtifier M	·	h		1	8118) UN E	i II,	Day, Year)
+10	+	30. Name and address of pe		pleted cause o	f death (Item	23a) (T	ype, Print) BESTGATE	AD B	NAMPU	LIS }	m	21401
Sta Registr		31. Date filed (Month, Day,)	1 3 200	32. R	strar's Signat	ure	ype, Print) BESTGATE					

上*NTH/CUM* , SyB/L Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

			Please	Type or Pri	nt in Bla	ack In	ndelible Ink	. Ensure A	II Copies	s Are	Legible.	
		For		State of M	aryland	/ Dep	artment of	Health and I	Mental Hy	/giene	9000	
		1 - State Registrar				Ce	rtificate of	Death		Reg. No	2001	60747
Physici	an	1. Decedent's Nam	e (First, Middle, L	ast)					2. Date of D	eath Da	y Year	3. Time of Death
/Medic		Sybil Jean	n Linthic	um					JUNE	1		1 3 28 PM
Examin	er		f not institution, gi	ive street and number,			0 . 1 .	or Location of Death		4c.	. County of Dea	th
		Sinai	Hospit		sultin			nove a	ly			
Funeral		5. Social Security N		Sex / 7. A	ge (In yrs. las	t birthday, Yrs.	If Under 1 Year Months Days		8. Date of Bi		9. Bir Co	thplace (State or Foreign ountry)
Director	Ğ	213-36-45			68	110.			August 1	10, 19	738 Ter	nessee
/land ow at		10a. State	10b. County		10c. City,	Town or L	ocation					10d. Inside City Limits
Man, -f sh fied	ţo	Maryland	Anne Arı	undel	Laurel							1 ☐ Yes 2 ☑ No
h the r 283	Director	10e. Street and Nu	mber				10f. Zip Code			10g. Cit	tizen of What Co	ountry?
filed within 72 hours after death with the Maryland Hygiene. Hygiene with an atural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at		407 Old Li	ne Avenue				20724			U.S.A		
ems er mu	Funeral	11. Marital Status		12. Was Decedent Armed Forces	Ever in U.S.	13.	Was Decedent of	Hispanic Origin? (Spoan, Mexican, Puerl	pecify Yes or N	0-	14. Race - Ame	
after or it			ied 2√ Married	1 ☐ Yes 2K If Yes, Give			1 ☐ Yes 2 ☑ No		o riioan, oto.,		Black, White	e, etc.
nours ural"	d by	3 Widowed		Year or Dates:				EEG				aucasian
"nat	ete	(Spec	15. Decedent's E cify only highest g	Education rade completed)		(Give	edent's Usual Occu e kind of work done	during most of wor.	king	16b. K	ind of Business	/Industry
withir ene. than	Completed	Elementary/Seco	ndary (0-12)	College (1-4or	5+)	ille.	DO NOT use retire Homemak	,			Own Hor	ne
filed Hygie ther		17. Father's Name	(First, Middle, Las	st)			пошешак	18. Mother's Nam	ne (First Middle	Maiden		
d be ental red o	Be C	Gudger Will		,						s, maiden	i oumame _j	
shoul mari	욘	19a. Informant's N		(Type, Print)		19b. Maili	ing Address (Stree	Lucille W t and Number or Ru		her City o	or Town State	Zin Cade)
nd 2 state and 2 s	3		•	Sr Husband	1			nue, Laurel			724	cip oode)
t Hea f Hea item othe	105	20a. Method of Disp			20b. Plac	e of Dispo	osition (Name of	1	Date		ocation - City or	Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and 2 should be filed within 72 hours after death with the Maral Highene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.			☐Cremation 3 [5 ☐ Other (Spec	☐Removal from State	4	-	matory or other pla	emetery 7/1	0/2007	A == 1 ± ==		
nit. F artmo	1	21. Signature of Fu			ALILI		2. Name and Addr		10/2007	Arli	ngton, Vi	rginia
Dep Imp any	0.0	Andr	01.	Man		Hi	nes-Rinald	i Funeral H	ome, Inc.	er Sn	ring Mar	yland 20904
		23a. Part1. Enter t	he disease, or cor	nplications that cause	d the death.						Ting, mar	Approximate
Physician	8 4	Immediate Cause	Final	y one cause on each l			-					Interval Between Onset and Death
/Medical		disease or condition resulting in death)	n		a consequer		0					
Examiner				Seps		,						
	ner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or	nditions, nmediate	b. Due to or as	a consequer	ice of):						
executed n and ial-transit	Examine	triat initiated events		. 1///	isote	y,	failu	re.				
be executed sician and burial-transit		resulting in death) I	_ast	Due to (or as		ice (f):	1					
ate b hysic the bu	lica			a Ener	phal	ypn	ly,					
sician: The law requires that the death certificate be excertificate has been signed by the attending physician rector, page 2 should be detached for use as the buria	Physician/Medical	IF FEMALE:		<i>v</i>		<u> </u>						
ath co	jan/	23b. Was deceden in the past 12		23c. If yes, outcome 1 ☐ Live birth	2 Fetal de	ath 3[⊒Ectopic pregnanc	у			23d. Date of del Month	*
the a	Sic	1 ☐ Yes 2 [9 ☐ Unknown	□No	4□Pregnant a 9□Unknown	t time of deat	h 5[Other (specify)				MOTH	Day Year
hat the d by detacl	PH	100		contributing to death b	ut not recultir	na in the u	Inderlying cause di	von in Port I	220 Did	toboooo	uso contributo to	the cause of death?
ires t signe	þ	CAD					indenying cause gi	venin Fait i.		Yes 2		_
requ	ece	CION	11	acerra hemadi						163 2		obably 4 Unknown
e law has t	Completed	2500	on	remady	acy 81	5			24a. Was	psy	prior to	topsy findings available completion of cause of
r. The	S	DWS						<u> </u>	perf 1□ Yes	ormed? 2/12 No	death? 1 ☐ Yes	2 □ No
ician certifi ector	Be	25. Was case refer examiner?		Hospital:			Tour	26. Place of Dea	th (Check only	оле)		
Phys this al dir	6	1 ☐ Yes 2 ☐ 27. Manner of Deat		1 Inpatie		Outpatier Bb. Time o	III OLI BOA				6 □Other (Spe	cify)
ding After funer	Certification:	1 Natural	5 ☐ Pending investigation	(Month, Da	y Year)	Injury	Wo	rk?]Yes 2∐No	28d. Describe	how injur	ry occurred	
death ctor: y the	Cal	2 ☐ Accident 3 ☐ Suicide	6 ☐ Could not b	De 28a Place of ini	urv - At home	. farm. str	reet, factory, office	1163 2 1100	28f Location	(Streat an	nd Number or D	ural Route Number,
lor A after Dire	erit i	4 Homicide	determined		c. (Specify)	, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,		City or To	wn, State	e)	rai noute Number,
spita ours neral		29a. Certifier	1 ☑ Certifying P	hysician: To the best	of my knowle	dge, deat	th occurred at the t	ime, date and place	and due to the	e cause(s)	and manner as	stated
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	(Check only one)	2 Medical Exa	miner: On the basis of and manner st	of examination	and/or in	nvestigation, in my	opinion, death occu	rred at the time	, date and	d place, and due	e to the cause(s)
To th Within To th Somp	Me	29b. Signature and	title of certifier)	2.5		29c. Licens	se number		29d. Dat	te signed (Mont	h, Day, Year)
2/		1 At	us,	N	10		30	063170		JUN	e 11,	1007
	-	30. Name and addr	ess of person who	completed cause of c	leath (Item 23	a) (Type,		1110				
ر کی		SYED		11, MD	Sino	' /	ton po to	u of	Balt	ma	me.	
Sta		31. Date filed (Mon	th, Day, Year)	007	ar's Signature	9	0					
Registr	ar	ال	JN 14 Z	OUT DERW	w B	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Month Year Hasey рМ Leo 2007 Geneva June 12 4:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1002 Helena Drive Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F 577-38-9617 79 Director April 3, 1928 Virginia Usual Residence of Decedent with the Maryland r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r 1002 Helena Drive 20901 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. ant If Item 27 is marked other than "natural", or ite ury or other traumatic event, the Medical Exmine 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 2 **X**No altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: ģ SpecifyWhite 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fabric Decorator Fabric Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jordan Goad Leona Nester ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Leo/Husband 1002 Helena Drive, Silver Spring, Maryland 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State June 14 Department of Important: If any injury of once. Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2007 Alexandria, Virginia 21. Signature of Funeral Service Licensee Francis Address Corlins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Congestive Heart Failure 2 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Coronary Artery Disease 5 Years Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for ea a consequence of): Examine executed Hyperlipidemia 40 Years burial-trar Due to (or as a consequence of): Box 68760. attending physician The law requires that the death certificate be Physician/Medical Hypertension 40 Years the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ō in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? or Vital Records, þ Aortic Stenosis, Aortic Insufficiency, 1 ☐ Yes 27 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an page 2 s Carotid Artery Stenosis autopsy performed? Yes 212 No 1□ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check onl one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home SE Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred al or Attending Fafter death.
I Director: After do in by the funers Division 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Funeral To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D15060 June 13, 2007

DHMH 17 Rev 1/2001

State

Registrar

10829 Georgia Avenue, #T2, Silver Spring, MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 egistrar's Signature

M.D.

14 2007

Peter S. Birk,

31. Date filed (Month, Day, Year)

			For State	State of Marylan				d Mental Hy	giene	on a new	
			Registrar	A	Cer	tificate of	Death	2. Date of De	Reg. No.		3. Time of Death
i d	Physici	an	1. Decedent's Name (First, Middle, Las					Month	Day	Year	6.40 PM
	/Medic		Willis Lenwood 4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of D	JUNE	4c. County of	-	6170 /11
Ä,	Examin	er				Hagers		eau	Washin		1
	Funeral		Washington County 5. Social Security Number 6. Se		last birthday)	If Under 1 Year	If Under 24		rth	9. Birthp	ace (State or Foreign
k	Director			X M 2□ F	72 Yrs.	Months Days	Hours N	vin. (Month, De January		Coun	try)
	D		Usual Residence of Decedent					journey	0, 92300		
	arylar show d at	_	10a. State 10b. County		y, Town or Lo					1	0d. Inside City Limits 1 ☐ Yes 2X No
	Ba-f s	Director	MD Washingto	n Ha	agersto						
	ith th	Dir	10e. Street and Number			10f. Zip Code	7.0		10g. Citizen of W		try?
	s 23a	Funeral	15514		0 140 1	21		0.40		SA · Americ	on Indian
	item:	nu	11. Marital Status 1 ☐ Never Married 2 【X Married	12. Was Decedent Ever in U. Armed Forces?	S. 13. V	vas Decedent of F f Yes, specify Cub	an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	Black	, White,	
36	rs aft	by F	3 ☐ Widowed 4 ☐ Divorced	1	1	☐ Yes 2☐No	Specify:		Specify:	7.71	nite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	ted	15. Decedent's Ed	ucation		ent's Usual Occup			16b. Kind of Bus	siness/Inc	
215	hin 7.	ple	(Specify only highest grad	College (1-4or 5+)	(Give life. D	kind of work done OO NOT use retire	during most of d)	working	Automot		
2	d with	Completed	9	College (1. Joseph)	Welde	er			Manufac	ture	
	be filed ntal Hygin od other event, tl	Be (17. Father's Name (First, Middle, Last)					Name (First, Middle		∍)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ဥ	Jesse Benjamin Mu					Elizabet			
Лаг	2 sh and Is m		19a. Informant's Name/Relationship (7	,	1	-		or Rural Route Numb			Code)
	1 and Health em 27 ther tr		Glendora Murray/V			+ National Name of	ar Pike	Hagersto	Wn, MD Z.		wn State
٥	Pages nent of h int: If ite		1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cren	natory or other pla					m, oate
altimore,	it. Pi	- 1	4 □Donation 5 □ Other (Specify 2 □ squature Furreral Service Licenters			Cemetery . Name and Addre			Big Pool		
Ba	permit. Departr Importa any inje		2 digitatine i uniera dei voe Electri	Horas					st Main S Hancock,		et 2 1750- 0368
-			23a. Part1. Enter the disease, or count shock, or heart failure. List only	lications that caused the death							Approximate Interval Between
	Physician	1 4	Immediate Cause (Final disease or condition	1)	COMP.						Onset and Death
	/Medical		resulting in death)	a. Die to (or as a consequ	uonoo of).	5	1 0		2.1		
	Examiner		Sequentially list conditions,	, Checuje	obstra	ruc live	Pulu	contry	Mea	20	
2	sit 9d	ine	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence to form the form to form the form to form the form to form the form to form the form to form the form to form the form to form the form to form the form th	uence of):						
h.	xecut and II-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):					+	
8760,	cate be executed physician and the burial-transit	dical E			·						
687		edic		d							
Вох	anding use	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregna		T-4i			23d. Date	of delive	ery
œ.	deat le atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pregnand Other <i>(specify)</i> _			Mon	ith	Day Year
P.O.	that the death certifit ed by the attending I detached for use as	by Physician/Me	9 Unknown								
	es be	by	Part II. Other significant conditions co	intributing to death but not resu	ulting in the ur	iderlying cause gi	ven in Part I.		tobacco use contri Yes 2 ☐ No	bute to tr 3⊟ Prob	
orc	w requir been si should	Completed	#					- ''	Tes ZINO	3 100	ably 4 Molikilowii
Sec.	has b	nple						— 24a. Was	psy p	rior to cor	psy findings available npletion of cause of
E	: The	Co						1□ Yes		eath? □Yes	2□ No
	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		. acinos lott	nor:	Death (Check only			
o	Phys r this ral dii	- To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Impatient 2 ☐ 28a. Date of Injury	ER/Outpatien 28b. Time of	1 3 DOA	4 LI Nursii	ng Home 5 ☐ Res	how injury occurre		/)
on	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Wo	rk?]Yes 2 ∐ No		now what y occurre	Ju	
Division or Vital Records,	Atten deat octor: by the	fica	3 Suicide 6 Could not be	286. Place of injury - At he	ome, farm, str	eet, factory, office			Street and Number	er or Rura	I Route Number,
5	al or a after al Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify	у)			City or To	wn, State)		
	To the Hospital or Attending Physiclan: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical (ysician: To the best of my kno niner: On the basis of examina and manner stated.							
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed		
)) 1 (1-01		02	1457		6-22	-2	750
,	10		30. Name and address of person who			Print)	c 1.1.	GERITONO	14.0	0.3	1 -
	Ve C'		31. Date filed (Month, Day, Year)	7 00(1)		THIL KV	E TIA	7 ERJ Jama	r. VVI)	111	42
7.05	Sta Registr		11 IN 9 8 2007	2. Registrar's Signa	A DOCK						

07-04675 Francis Mae Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

-rancis Mae	1- For State Certificate of Death Reg. No.	17 8095
Physician/	1. Decedent's Name (First, Middle,Last) 2. Date of Death	3. Time of Death
Medical Examiner	Frances Joyner May June 18, 2007	2119 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea 4c. County of Dea 4d. Co	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. B Annual Processing Security Number 240–82–7932 1 May 2 F 58 Yrs. Sept. 11, 1948 Fore	irthplace (State or ign North ountry) Carolina
the supplement that the	Usual Residence of Decedent	
ow any	10a. State 10b. County 10c. City, Town or Location 10c. Ci	10d. Inside City Limits 1 Yes 2XXXNo
ryland a-f sho	10e. Street and Number 10g. Citizen of What Co	
th the Maryland 3a or 28a-f shu notified at once	6808 Haven Avenue 20745 USA	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Realth and Mental Hygiene. Italian 27 is marked other than "natural", or Items 33a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	3 Widowed 4 A Divorced in res, Give year 1 Yes 2 No specify: Specify: Specify:	rican Indian, Black, Black
5-0036 ed within 72 hours tygiene. the than "natur the Medical Exam Completed 1	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 College (1-4 or 5+) Accountant 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accountant Green Peace	
5-00 ed with tygien other inc Me	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medica	Zethra Joyner Irene Turner	
1D 21 2 should and Me 27 is ma matic ev	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Star William May / Son 16302 Ayrwood Lane Bowie, Maryland 20716	te, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that injury or other traumatic event, the Medic	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City of Cremation 3 X Removal from State Crematory or other place)	
timent riment riment vor ot	4 Denation 5 Other Specify: Missionary Baptist Ch. Cem. 06/22/2007 Kenly, North	
	Sugar P. Kalas - 6160 Oxon Hill Road Oxon Hill, Maryland	20745
Physician /Medical	23a. Part / Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line immediate Cause (Final disease a. Hypertensive atherosclerotic cardiovascular disease	Approximate Interval Between Onset and Death
⊆xaminer	Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Imperiteristive attrieroscrerotic cardiovascurar disease Due to (or as a consequence of):	
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Cheece of failure that initiated Cheece of failure that initiated cause.	
uted S		
60, nate be execu hysician and ne burial - tra	X unpended X 4MENDEBa,27, perME, g868, 6/29/07 TT	
1760 ficate the physic the pu		Day Year
by the attending sched for use as the Physician!	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (Specify)	Day Tear
Bo he deal y the all hed for	Yes 2 No 9 V Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute t	o the cause of death?
P.O. res that the signed by be detac	1 Yes 2 No 3 Pro	_
Records, The law requires ficate has been signage 2 should be Completed	24a. Was an 24b. Were a autopsy prior to	autopsy findings available completion of cause of
Recort the la	performed? death? 1 ✓ Yes 2 No 1 ✓ 1	
tal I	25. Was case referred to medical 26.Place of Death (Check only one) examiner?	
of Vi Physi ter this eral dir	7 No 2 No	er: Scene
on c ending ath. rr: Aft he fund	1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No	
Division of Vital Records, P.O. Box 68760, spiral or Attending Physician: The law requires that the death certificate be executed to rours after death. neral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial - transit Certification: To Be Completed by Physician/Medical Ex	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 28f. Location (Street and Number or For Town, State)	Rural Route Number, City
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certification: To Be Completed by Physician/Medical Exan	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
N E S E S O	29b. Signature and title of certifier 29c. License number 29d. Date signed (M	onth, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)	
	Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registrar		
DHMH 17 Rev 1/2001	ORIGINAL	

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f sh notified

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partment of H portant: If iten y injury or oth

Medical

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Director

Funeral

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Completed

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with the Maryland

filed within 72 hours after death

altimore, Maryland 21215-0036

physician and the burial-trans as nse ate has been signed by page 2 should be detac

The law requires that the death certificate be executed

Box 68760.

P.0.

Division or Vital Records,

Physician/Medical ģ Completed Be ٩ filled in by the f

Certification:

Medical

To the Hospital o within 24 hours aft To the Funeral D State Registrar

or after

Examiner

investigation 6 ☐ Could not be

XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier MD

determined

29c. License number D-32332 29d. Date signed (Month. Dav. Year) JUNE 09, 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SURESH K. GUPTA, M.D. 9801 GEORGIA AVE. STE. 220 SILVER SPRING, MD 20912

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

JUN 1 4 2007



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year Martin June 6, 2007 /Medical 9:49 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hospital Cheverly Prince George's 5. Social Security Number If Under 24 Hrs. 6 Sax If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🕅 F Director 577-74-1178 83 South Carolina Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location or 28a-f ehow 10d. Inside City Limits the Medical Examiner must be notified at District of Columbia Director Washington Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5011 Ayers Place SE or Items 23a 20019 Funerai United States 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, o filed within 72 hours after do Hygiene. Hygiene. other then "naturel", or Item Black, White, etc. 1 Never Married 2 Named 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: à 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Homemaker Private other 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be file ment of Health and Mental Hy tant: If Item 27 is marked oth 18. Mother's Name (First, Middle, Maiden Surname) Be Effert Matthews ပ Gertrude Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vickey Martin - Daughter 5011 Ayers Place, SE Washington, DC 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if Ite
eny injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐Donation 5 ☐ Other (Specify) Harmony Mem. Park June 11, 2007 Landover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final Diabetes Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, Tary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Dua to (or as a nonsequence of) and The law requires that the death certificate be executed physician ar Due to (or as a consequence of): attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 meenths? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) a detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 1 Yes 2 No 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 🌠 ER/Outpatient 3 ☐ DOA Director: After this of in by the funeral director ٩ 1 Yes 2 No Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury after death. 1 Tes 2 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29b. Signature and title of certifier

State

Baltimore, Maryland 21215-0036

P.O. Box 68760.

of Vital Records,

Division

C. Donald George 3001 Hospital Drive Cheverly, MD 20748 32. Registrar's Signatua

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

D58182

29d. Date signed (Month, Day, Year)

June 7, 2007

			For State Registrar	State of I	Maryland / [rtment <i>tificate</i>			and M	F	Reg. No.	07	209	55
	Physici		Decedent's Name (First, Middle, L Ramon	S.	Ŋ	Manungas						2. Date of Death Month 12, Day 2007 Yea 4c. County of De Prince G			Death M
	/Medic Examin		4a. Facility Name (If not institution, gi Ft. Washington Hosp					4b. City, Town, or Location of Death Ft. Washington							
	Funeral Director		559-48-4281	Sex 7. 1XXXM 2□F	Age (In yrs. last bir 85	rthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	Min.	B. Date of Birth (Month, Day Dec. 18,	1921	9. Birthy Cou Ph	place (State on ntry) ilippine	r Foreign S
	Maryland f show led at	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Prince (George's	10c. City, Tow		ation eights							10d. Inside Ci 1 ☐ Yes	
	with the a sor 28a-	Direct	10e. Street and Number 10f. Zip Code 20745									10g. Citizen o	f What Cou	ntry?	
36	J within 72 hours after death with the Maryland jiene. Than "neturelt, or Items 23s or 28s-f show The Medical Exame not mark be collified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	ont Ever in U.S. os? □ No os: 19491972	1	Was Decedent of Hispanic Origin? (Spef Yes, specify Cuban, Mexican, Puerto f				ecify Yes or No- Rican, etc.)	ack, White,	American Indian, White, etc. Filipino			
Maryland 21215-0036	vithin 72 hou ne. han "neture a Medical E	Completed	15. Decedent's (Specify only highest g	Education	16a	Decede (Give k life. D	ent's Usual sind of work O NOT use Petty	done o	during mos ()	t of work	ing	16b. Kind of	Business/Ir Navy	ndustry	
land 2	be filed ntal Hygi ad other event, I	To Be Co	17. Father's Name (First, Middle, Las UNKNOWN	ot)		инег	recty	OLL		er's Name	e (First, Middle,				
Mary	and and sum		19a. Informant's Name/Relationship Sonoko Manungas / W								al Route Numbe				
Baltimore, I	ages 1 and 2 ant of Health it: If item 27 it y or other tre		20a. Method of Disposition 1 □ Burial 2 XXC remation 3 1 □ Donation 5 □ Other (Spec	□Removal from Sta	20b. Place o	of Dispos ary, crem	ition (Name atory or oth		e)		Date 3/2007	20c. Location	•		
Baltir	permit. Pages Department of h Importent: If ite any injury or of once.		21. Signatur (Funeral S Nice Lice		Relicio	22.	Name and	Addres	ss of Facilit	y Geo ad Ox	rge P. Ka on Hill, l	las Fune	ral Ho	me PA	
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68760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or	as a consequence	of):									
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I Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed by	prostate 7	amor,	Dubet.	es R	1e[[, Xns	type	1	24a. Was autop perfo 1 Yes		o. Were aut prior to co death? 1 \(\sum \text{Yes}	opsy findings ompletion of c	available ause of
of Vital	Physicien: Th this certificate ral director, pag	To Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 □ Inc	patient 25ZER/O	utpatient	3 DO/	A Oth	or		h <i>(Check only o</i> ome 5 🗆 Resid		Other (Spec	ify)	
	Jing After fune										28d. Describe I	how injury occ	urred		
Division	al or Attsndi s after death. sl Director: A sd in by the fu	Certification:	3 Suicide 6 Could not 4 Homicide determine	200. Place U	f Injury - At home, fi , etc. <i>(Specify)</i>	arm, stre	et, factory,	, office			28f. Location (S City or Tox	Street and Nur wn, State)	nber or Rui	ral Route Num	nber,
	To the Hospital or Attank within 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier (Check only one)	Physician: To the b aminer: On the bas and manne	is of examination at	ge, death .nd/or inv	estigation,	in my o	pinion, dea	nd place, ath occur	red at the time,	date and plac	e, and due	to the cause(:	s)
)	To the To the comple	Ň	29b. Signature and title of certifier		ma	2			3 7	06		29d. Date sign			
R	(20) Wa		30. Name and address of person where the control of	o completed cause	of death (Item 23a)) (Type, F	orint) 6	188	PX	on H11	HILL	RD	# 7076	15	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) JUN 1 4 2007	Beiew X	nistrar's Signature	Ü	•								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** Ella Agnes Moore 3:00 Рм June 11 2007 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 1 ☐ M 2 1/2 F Yrs 212-42-7158 92 **Director** Jan. 16, 1915 New_York Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exame and must be invitibed at Maryland Anne Arundel Annapolis 1 Yes 2010 Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 970 Rivers Edge Circle 21401 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes **2∕CXN**o If Yes, Give Year or Date*s*: 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: Completed by White 3€Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman Otto Sattmary Cecilia Lykke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dennis F. Hollidayoke/son 3181 Raven Court Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Anne's Cemetery 6/15/2007 Annapolis, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 11 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (PESMONIA 7 12566 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): as IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Noknown EMPHYSEMA as been si Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2000 2 🗆 No certificate 1 Yes 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 patient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 200 Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 Hatural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 🗲 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of c D39037 107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Parkway Annapolis, Maryland DS MITCHELL 31. Date filed (Month JUN 1 3 2007 gistrar's Signature State Registrar

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Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State o	of Maryla	-	artment of F <i>rtificate of</i>		nd Mental H	ygiene Reg. No.		
	No.		Decedent's Name (First, Middle, La	st)			2. Date of D	Death 3. Time of Death				
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	Examir		4a. Facility Name (If not institution, give	re street and nu	mber)		4b. City, Town, o	r Location of D	Death	4c.	County of Death	
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	3a or		9395 Legion Road				21629			U.S		, .
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21215-0036	be filed within 72 hours after death with the Maryland Ital Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	b	1 □ Never Married 2 □ Married 3 🛣 Widowed 4 □ Divorced	orces? 2 X] No ve oates:		r Yes, specify Cub. I∐Yes 2∏X No	an, Mexican, F Specify:	Puerto Rican, etc.)		Black, White, etc. Specify: White		
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Maryland			19a. Informant's Name/Relationship						or Rural Route Num	-		
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Baltimore,			4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice	•	G		nt Cemete . Name and Addre		/20/07	Hil.	lsboro,	Maryland
Ba	permi Depar Impor any ir		les (12	_				enbein Fu	ineral rylar	L Home,	PA
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Вох	death certific e attending pl d for use as t	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			I=			2	23d. Date of deliv	rery
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Records,	w require								_ _ 10	Yes 2	JANo 3□ Pro	bably 4 □Unknown
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8	ate pag	No.								formed?	death?	`_
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Division	or A after of Direct in by	Certification:	4 ☐ Homicide determined		ing, etc. (Spec		et, factory, office		City or To	(Street and own, State)	Number or Hur	al Route Number,
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			30. Name and address of person who Karen Moffett			em 23a) (Type, I f i n Land		m. Mar	yland 216	529		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Month Year Daniel V. San Miguel 2007 /Medical June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hagerstown Jnder 1 Year | If Under 24 Hrs. nths | Days | Hours | Min. 20435 Kings Crest Boulevard . Social Security Number 6. Sex Washington 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F Yrs. Director 262-73-5565 Philippines July 20, 1916 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 ☐ XNo Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of What Country? "natural", or items 23a or adical Examiner must be r 20435 Kings Crest Boulevard 20742 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. ☐ Yes 2 📆 No Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo If Yes, Give Year or Dates: Specify: Specify Asian \$ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) r than " Elementary/Secondary (0-12) College (1-4or 5+) Tax Assessor State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cosine San Miguel Paula Vallestero မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adelina San Miquel/Daughter 20435 Kings Crest Boulevard, Hagerstown, MD 20742 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State June 15, 4 Donation 5 Other (Specify) Gate of Heaven Cemetery 2007 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Cancer of Pancreas /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, flag, bearing to interest cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last End-Stage Renal Disease Due to (or as a consequence of) Examine Congestive Heart Failure burial-trai Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Liver Cirrhosis, Arteriosclerotic Cardiovascular Disease, Hypertensi Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2∐No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home State Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No 2 ☐ ER/Outpatient 3 ☐ DOA ၀ 1 | Inpatient After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, or Attending Physician: after death hin 24 hours a

filled in by the funeral director, completely

> State Registrar

Medical

31. Date filed (Month, Day, Year) 4

29a. Certifier

one)

29b. Signature and title of certifier

OFAL

30. Name and address of person who completed cause of leath (Item 23a) (Type, Print).

Has 32 Registrar's Signature

📭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

COVYECES,

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month EMONY MOWELL 2007 816 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BATTI MORE UNIVERSITY OF MARY LAND MEDICAL CONTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, Year) June 23 1967 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 230-06-8756 1**⊠**M 2□F 39 Director Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a.f ehror any injury or other traumatic event, the Medical Example. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Md. Howard Mount Airy Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 18848 Windsor Forest Road 21771 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 No Specify: <u>م</u> Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Landscaper Landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Mowell Ethel Bernice Christian Emory ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18848 Windsor Forest Road, Mount Airy, Md. 21771 Rose A. Mowell / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ricketts Cemetery 6/14/07 Derwood, Maryland 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Name and Address of Eacility Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** NEUMERIA /Medical Due to (or as a consequence of) Examiner ACUTE MYELOGENOUS LEYKEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed signed by the attending physician and I be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dead 4 ☐ Pregnant at time of death 9 ☐ Unknown Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1☐ Yes 2 1 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificd completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Year

29d. Date signed (Month, Day, Year)

2007

State Registrar DHMH 17 Rev 1/2001

LIANG 31. Date filed (Month, Day, Year) 1 4 2007

29a, Certifier

(Check only one)

STEVEN

29b. Signature and title of certifier

Medical



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

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MD

			1 - For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of I rtificate of		Mental Hy	rgiene Reg. No. 🥎 🖺	117		
l	Physici /Medi		1. Decedent's Name (First, Middle, Las Charles Joseph Mor	,				2. Date of De Month June 9	Day	Year 3. Time of Death 2:15 p M		
	Examir											
3	Funeral Director		5. Social Security Number 6. S 363-22-9202 Usual Residence of Decedent	ex 7. Age 1 M 2 F 8.	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days		. (Month, Da	rth ay, Year) 24, 1923	9. Birthplace (State or Foreign Country) Michigan		
	Maryland -f show iled at	tor	10a. State 10b. County Maryland Montgo		10c. City, Town or Lo			_		10d. Inside City Limits 1 ☐ Yes 2X No		
	with the 3a or 28a st be notif	Funeral Director	10e. Street and Number 10242 Democracy I	-		10f. Zip Code	854		10g. Citizen of W	•		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E- Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:	ver in U.S. 13. D WWII	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Specify Yes or Norto Rican, etc.)	o- 14. Race	- American Indian, s, White, etc. White		
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Baltimore,	t. Pages I rtment of H rtant: If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Ft. Linco	matorý or other pla oln Crema	tory 6/1	Date .5/2007	Brentwoo	City or Town, State		
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)	Vithin To th To th Comp	Me	29b. Signature and title of certifier!	id Der	s(c: m)	29c. Licens			29d. Date signed June 12	(Month, Day, Year) 2, 2007		
			30. Name and address of person who of Geneviere Wroblew	ski, M.D	1335 Picc		e, Suite	100, Ro	ckville,	MD 20850		
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Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

2007

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32 Registrar's Signature

	an	1. Decedent's Name (First, Middle, Last	*	111 D D O 11				2. Date of Dea		Year	3. Time of Death
/Medi				MADDOX				JUNE 13			12:35 A
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other traumatic		19a. Informant's Name/Relationship (T)						al Route Numbe			
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≒ 5		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		ARLINGTO				13,			VIRGINIA
Important: any injury once.		21. Signature of Funeral Service Licens		000=-	2. Name and			NTT FUN			20601
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6. Jr	Jer	if any, leading to immediate	b. Due to (or as	a consequence of):	. 3		2				1000
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attending p for use as i	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		7				23d. Da	ate of delive	ery
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neral director,	:lou:			ury - At home, farm, st				28f. Location (S	Street and Num	ber or Rura	al Route Number.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene (1)

			For State Registrar		State	of Mary	land / Depa		of Death			eg. No.) /	20963		
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l	Funeral Director		5. Social Security Number 287–32–0831		M 2 F		yrs. last birthday) 74 Yrs.	If Under 1 Months D		Min.	8. Date of Birth (Month, Day) Mar. 28	, 1933	9. Birthp Coun Ohi	lace (State or Foreign try) .O		
	death with the Maryland ms 23e or 28a-f show	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location										1	0d. Inside City Limits			
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30	be filed within 72 hours after death with the Marylan tal Hygiene d other than "natural", or items 23s or 28s-f show event, the Madical Extrational burntified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Div		12. Was Dec Armed F 1 Tes If Yes, G Year or I	orces? 2 ∑X No ive		was Decedent f Yes, specify 1 ☐ Yes 2 ☐			scify Yes <i>o</i> r No- Rican, etc.)	Specify	e - Americ ck, White, Whit	etc.		
12-003e	tural			cedent's E		ion 16a, Decede			dent's Usual Occupation				6b. Kind of Business/Industry			
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3	T. FALL	Jer	Sequentially list conditions if any, leading to immediate Cause (Disease or injury		b. Due to	(or as a co	nsequence of):									
	cuted nd ransit	Examiner	that initiated events	1	c											
Š,	e exe	EX	resulting in death) Last	- 1	Due to	(or as a co	nsequence of):									
2/PU	lificate be executed g physician and as the burial-transit	edlcal			_ d											
٥	ding p		IF FEMALE: 23c. If yes, outcome of pregnancy										22d Date of delivery			
X Q Q	death cer e attendir od for use	hysician/M	23b. Was decedent pregna in the past 12 months		1 ☐Live		Fetal death 3	Ectopic pregi				23d. Date of delivery Month Day Year				
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cords, r	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by P	Part II. Other significant co	onditions	contributing to	death but no	t resulting in the u	nderlying caus	e given in Pan	t I.	23e. Did to	obacco use contribute to the cause of death?				
	law req as beer 2 shou	ompleted									24a. Was a	n 24b.	Were auto	psy findings available		
E E	The lar ate has page 2	шо									autops	med?	prior to cor death? 1 🗌 Yes	inpletion of cause of		
<u>[a</u>	ician: The lar certificate has rector, page 2	e C	25. Was case referred to n	nedical					26. Pla	ce of Death	1 Yes	A	1 1 1 4 3	20140		
>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 No		Hospital: 1	Inpatient	2 ER/Outpatien	t 3 DOA	Other: 4 1	Nursing Hor	ne 5□Reside	ence 6 🗆 Oth	er (Specify	/)		
0	ng Pt fter th ineral		27. Manner of Death	Pending	28a. Date (Moi	of Injury oth, Day Ye	ar) 28b. Time of Injury	28c	Injury at Work?	2	28d. Describe he	ow injury occur	red			
<u>0</u>	eath. or: A the fu	catle	2 Accident	nvestigatio				М	1 Yes 2							
UIVISION	after d Direct d in by	ertification:		determined	288. Plac	e of Injury - ding, etc. (S	At home, farm, str pecify)	eet, factory, o	ffice		28f. Location (Si City or Towi		er or Rura	I Route Number,		
	To the Hospital or Attending Phys within 24 hours after death. Yo the Funeral Director: After this dompletely filled in by the funeral directors.	Medical C			miner: On the I		y knowledge, death mination and/or in									
	Fo the	Me	29b. Signature and itie of	ertifier	1			29c. L	cense number	r	2	9d. Date signe	d (Month,	Day, Year)		
	(4)		1 then	hl	X,	0 a	ND	i)585	5/0		61	81	7		
	000		30. Name and address of p	erson who	completed cau	ise of death	(Item 23a) (Type,	Print)				01	-la	1		
5	28		Stephe	n	Oler		2001 Med.	ical P	cwy.	Annap	olis, M	D. 21	401			
έτ	Sta Registr	2.0	31. Date filed (Month, Day 1UN 1 3 200)	Year)	32.	Hegistrar's	mature									

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June ^{ay} 07 **Physician** 19 2212hrs Eleanor Muir /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11105 Ore st Cumberland Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min 1 ☐ M 2 📈 F Maryland Director 214-32-3123 78 August 30, 1928 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Iteme 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 Yes 2 No Director Cumberland Maryland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 11105 Ore Street N.E. 21502 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examinat Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: Ž 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LPN 12 0 Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hugh Muir Marie Catherine Winter 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George Kroll - Cousin 17227 Luznar Lane, Frostburg, Maryland, 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State June 22, Frostburg, Maryland Frostburg Memorial Park 2007 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. 21. Signature of Funeral Service Licensee 3 8 East Main Street, Lonaconing, Maryland 21539 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Hypertensive cardiovascular disease 12 4 /Medical Hyperlipidemia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 Villo
9 Unknown Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Hypothyroidism 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificete has To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident Injury 5 Pending 1 TYes 2 TNo investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifiei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 24 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09157 June 20 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dpty Med Ex 124 w 3rd st Cumberland Md 21502 Snow, M.D. 31. Date filed (Month, Day, Year) State JUN 22 200 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month PM Iune 20. 2007 7:35 Howard Gustav Myers, Ir. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ruxton Health of Denton Caroline 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1⊋M 2□F Hours Director 212-26-9448 76 Maryland September 8, 1930 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1√2Yes 2□No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3310 Fleet Street 21221 United States of America Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ∑Yes 2 No Yes, Give 1 ☑ Never Married 2 ☐ Married 1953-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Caucasian 3 Widowed 4 Divorced 1955 Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer City of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Evelyn Preifer Howard Gustav Myers, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emil C. Myers Brother Lou Av enue, Denton, Maryland 20b. Place of Disposition (Name of cemolery, cjemetery of other place)
Mary (And Castern Shore
Veterans' Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 6/25/2007 Hurlock, Maruland 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street, Signature of Funeral Service Lipe 1000 Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** end 5+age CITTNOSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underl, in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine al or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and by the unreal director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 TYes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

within 24 hours at To the Funeral D

29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00053255 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Preston MD 21655 Butter Lednum Hve 136 31. Date filed (Month State Registrar

one)

State Registrar

within 2

PAGTICAL JUN 1 3 2007

29b. Signature and title of certifi

Aprito, mo

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

139 Old Solomons Island Road, Annapolis MD

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE BEVERLY BONITA ELAINE EWING PALMER 08, 2007 11:22A^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 □ M 2\(\text{X}\)F 579 56 9471 JUNE 13, 1939 WASHINGTON, DC Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits XX Yes 2 No MD PRINCE GEORGES LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1623 VILLAGE GREEN DRIVE 20785 UNITED STATES 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify. Specify: BLACK XX Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) YRS. STATISTICAL ASSISTANT DEPARTMENT OF COMMERCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HERBERT TALMADGE EWING DOROTHY BROOKS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KIMBERLY A. PALMER-WILLIAMS/DTR 1919 MONTEZUMA STREET STOCKTON, CA 95205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON NATIONAL CEM.6/18/07 SUITLAND, MD 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MARYLAND, 21. Signature of Funeral Service Licensee 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) erustum Due to (or as a consequence of): Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 1∐ Yes 2 **X** No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Inpatient 2 XER/Outpatient 3 □ DOA

Physician /Medical Examiner

Department of H Important: If ite any Injury or ot once.

Pages 1 and 2 should be file ment of Health and Mental Heart: If item 27 is marked oth jury or other traumatic even jury or other traumatic even

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

"natural", or Items dical Examiner m

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Director

Funeral

δ

Completed

Be

Examine the burial-trai Physician/Medical use o signed by the a þ Completed funeral director Be Certification: To

or Attending Physician: The law requires that the death certificate be executed after death. filled in by the 24 hours a Hospital

Division or Vital Records, P.O. Box 68760,

Medical To the I within 2

State Registrar 27. Manner of Death 1 Natural 2 ☐ Accident 5 Pending investigation 3 Suicide 4 Homicide

29a. Certifier

(Check only

29b. Signature and title of certific

6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of

and manner stated

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? Injury

1 Yes 2 No

29c. License number

DRIVE

to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

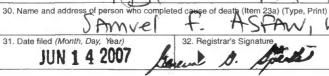
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THR LITTLE MID 3001

31. Date filed (Month, Day, Year)

32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 345 am **Physician** uno LINDA L. PHELPS /Medical 2007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Prince George's Lanham If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Min. Days 1 □ M 2 🗹 F Director 214-52-4241 58 11-06-1948 Washington, DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 ☐ No Maryland Prince George's Cottage City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4014 Parkwood Street 20722 Funeral U.S.A. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify ģ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Important: If Item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Fire Protection 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental F Otho T. Jarratt, Jr. Helen L. Rhodes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 si Health an James L. Phelps, Jr. - Husband 4014 Parkwood Street, Cottage City, MD 20722 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/16/2007 George Washington Cem. Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. $^{2}3$ Gasch's Funeral Home, P.A. Hyattsville, MD 20781 from 23. Part1. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ESDIVATOR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of) Examine burial-tran Due to (or as a consequence of) P.O. Box 68760 physician OCOCCUS AVIEWS Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9☐Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Obstructive 1 es 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 2 X No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 🗌 Yes 2 100 1 npatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) e Hospital or Attending Pl 24 hours after death. e Funeral Director: After t 27. Mann of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) JUN 1 4 2007



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mp 8/186000 Lucilled., Lanham, MD. 20706

altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month **Physician** James Leo Poulette 2007 June РΜ 3:53 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 305 Glyndon Drive Reisterstown 8. Date of Birth (Month, Day, Year) June 30,1960 If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Funeral 1√X 2□ F Washington D.C. 217-76-0280 46 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f sh notified 1 ☐ Yes → No Directo Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r 305 Glyndon Drive 21136 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iter any injury or other traumatic event. 1 ☐ Yes 2 ☑ Wo If Yes, Give XX Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XX No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Real Estate Investment Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph L. Poulette Doris L. Carl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Poulette / Wife 305 Glyndon Drive Reisterstown, Maryland 21136 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State TGBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lakemont Mem. Gardens 6/15/2007 Davidsonville, Maryland 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. Miches 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Landioussa lan VISCO 8 disease or condition resulting in death) /Medical e to (or as a consequence of) Examiner Sayus field list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the aid 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has bage 2 s autopsy perfori certificate 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) ို 1 Inpatient After this filled in by the funeral 27. Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No Director 6 ☐ Could not be 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year) Date filed (Mo State JUN 13 2007 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Maryl		artment of H rtificate of			giene	.7	2057)
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1	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death	_	4c. County	4	
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	Funeral		5. Social Security Number 6. Se 229 – 78 – 8453	etu ome	rs. last birthday)	Months Days	II Under 24 Hrs. Hours Min.	S. Date of Birt (Month, Day	h y, Ye <i>ar</i>)	9. Birtho	place (State or Foreign
ш	Director		Usual Residence of Decedent	*** 2UF 69	Yrs.				1937	Gr	reece
	and		10a. State 10b. County	10c.	City, Town or Lo	ecation				1	I Od. Inside City Limits
	Mary feb	ō	MD Montgo	mery	Silver	Spring					1 ☐ Yes 2X☐ No
	28°	ect	10e. Street and Number	-		10f. Zip Code			10g. Citizen of W	/hat Cour	ntn()
	With With	Funeral Director	1328 Twig Terr	ace		209	05		•	SA	my.
	ne 2;	era	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.	Was Decedent of I	Hispanic Origin? (Si	pecify Yes or No-	14. Race	- Americ	can Indian.
(0	riter	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 1 No			Hispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	Black	k, White,	etc.
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-1 ehow fre Modical Exercities mast be routified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usual Occup	nation	ting	16b. Kind of Bu	siness/In	dustry
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Baltimore,	Page ent o nt: If ry or		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,	Removal from State	b. Place of Dispo cemetery, crer Gate o	nation (Name of matory or other pla E Heave	^{ce)} 6/13	/2007	Silver	-	own, State ring, Md
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the fo	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my liner: On the basis of exam and manner stated.	knowledge, death ination and/or inv	n occurred at the tir restigation, in my o	ne, date and place, pinion, death occur	and due to the orred at the time, o	ause(s) and mar late and place, a	ner as st	ated. the cause(s)
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			30. Name and address of person who co	ompleted cause of death (I	tem 23a) (Type,	Print) 2101	med	ical P	ait 1	or	
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	Registr	ar	JUN 14 20	IUI REMEDIE	7.5° /23						

		For State Registrar	State of M		Оера		t of H	ealth a		-		ie 2.0	17	2097
Physici /Medic		Decedent's Name (First, Middle DONALD)	e, Last)	ROGE	RS			<u></u>		2. Date of D Month 06	eath D		ear)7	3. Time of Death 1245 P. M
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Funeral Director		5. Social Security Number 219–66–8872	6. Sex 7. Ag 1	je (In yrs. last bii 50	thday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D	ay, Yea			ace (State or Foreigr ry) LAND
e Maryland 3a-f show tiffled at	Director	Usual Residence of Decedent 10a. State 10b. County MD ALI	LEGANY	10c. City, Tow		cation RLAND							10	0d. Inside City Limits 1 X Yes 2 □ No
th with th 23a or 24 ust be no	al Dire	10e. Street and Number 473 GOETHE ST	REET			10f. Zip	Code L502				_	Ditizen of Wh ${\sf J.S.A.}$	at Count	ry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 X Mar 3 □ Widowed 4 □ Divorced	If Yes, Give			Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexicar Specify:	gin? (Sp i, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - Black, Specify:	America White, e	etc.
within 72 ho iene. than "natur he Medical I	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12) 12	nt's Education est grade completed) College (1-4or		(Give life. l	dent's Usua kind of wor DO NOT us ERK	l Occupa k done d e retired	ation <i>luring mos</i>)	t of work	ing	I	Kind of Busin		ustry OUSTRIES
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and 2 sho alth and 1 27 is ma er trauma		19a. Informant's Name/Relations BRENDA ROGERS								al Route Num. 1BERLAN			ate, Zip 502	Code)
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ospital or Attending F hours after death. uneral Director: After ly filled in by the funer	Certification:	3 Suicide 6 Could 4 Homicide deterr	nined Zoe. Flace Utili	jury - At home, fa tc. <i>(Specify)</i>	arm, str	reet, factory	, office			28f. Location City or To			or Rural	Route Number,
To the Hospital or Attend vithin 24 hours after death to the Funeral Director; completely filled in by the	Medical C	29a. Certifier Check only Check on Ch	ng Physician: To the best I Examiner: On the basis of and manner s	of examination at	e, deat nd/or in	h occurred evestigation	at the tin , in my o	ne, date ar pinion, dea	nd place ath occu	and due to th	e cause e, date a	(s) and mani and place, an	ner as sta d due to	ated. the cause(s)
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on Type or Drint in Plank Indelible Ink

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

	1	Yes	2
6. Place of Death (C	Check	only	one)
4 - November 11		1 -	

IWAM

29b. Signature and title of certifier

29c. License number D25406 29d. Date signed (Month, Day, Year) JUNE 12, 2007

4 State Registrar

Amo

32. Registrar's Signature

31. Date filed (Month, Day, Year)

JUN 2 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** ROBERT R. RIGOT JUNE 19, 2007 1:45 A.M. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON REEDER'S MEMORIAL HOME BOONSBORO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7/12/1937 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Vear) 1X M 2□F OH10 69 Director 232-54-8679 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 X No **Funeral Director** WV BERKELEY MARTINSBURG 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 48 TARLETON DRIVE 25403 USA Was Decedent Ever in U.S Armed Forces?, 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 **X**lo 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) BROWN FUNERAL Elementary/Secondary (0-12) College (1-4or 5+) FUNERAL DIRECTOR/OFFICER HOMES, INC. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be HERMAN RIGOT JEANETTE FORNARI ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 48 TARLETON DRIVE, MARTINSBURG, WV 25403 M. PATRICIA RIGOT/SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ROSEDALE CEMETERY 22, 2007 MARTINSBURG, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME. P.O. BOX 821, Charles M. L 327 W. KING ST., MARTINSBURG, WV 25402 low 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of): da /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unseas or Iriginy that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner physician and s the burial-trans The law requires that the death certificate be exec Due to (or as a consequence of): Box 68760, as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9□Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II**. Other significant conditions** contributing to death but not resulting in the underlying,cause given in Part I Division or Vital Records, þ 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy this certificate 1☐ Yes 2☑ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 ■ Natural 2 ■ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 032518 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

0,

State

21 WYAND DRIVE, KEEDYSVILLE, MARYLAND 21756

31. Date filed (Month, Day, Year)

RUBERT GUEDENET

JUN 2 8 2007

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last). 2. Date of Death 3. Time of Death **Physician** MERRILL Month Year 07/6 M EICH 06 2007 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mandrin Hospice House Anne Arundel Harwood If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** M 2 □ F 76 265-36-1682 Director 28, Washington, DC Aug. 1930 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 21s marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must he and once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1605 Stern Court 21409 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White ģ Specify: 3 X Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Naval Officer U.S. Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Merrill Dale Reich Evelyn Merle Wright ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexandra Childs/daughter 39 Russell's Way Westford, Massachusetts 01886 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ remation 3 ☐ Removal from State Ft. Lincoln Crematory 6/15/2007 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature 11 meral S rviv Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Immediate Cause (Final disease or condition resulting in death) **Physician** 10 Ġ /Medical Due to (or as a cons quence of): Examiner MYOTROPHIL Superitary fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe page death? 1 □ Yes this certificate 2□ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ို 2[X No 1 🔲 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ②Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 □ Pending 1 □ Yes 2 □ No investigation within 24 hours after death

To the Funeral Director:

completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination another investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number Chief Medical Officer D 21438

State

Registrar

31. Date filed (Month, Day, Year) JUN 1 3 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospice of the Chesapeake, 445 Defense Highway, Annapolis, MD 2140] gistrar's Signature

Michael J. LaPenta, M.D.,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** LISABETH 22 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BURNIE AMME BATTIMORE WASHINGTON MEDICAL CENTOR HRUNDE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖼 F Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. Count 10d. Inside City Limits 28a-f show Director event, the Medical Examiner must be notified 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 1.5.A. "natural", or items 23a permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1254DEN4 MD. 21122 20b. Place of Disposition (Name of cemetery, crematory or other Date 20a. Method of Disposition 20c. Location - City or Town, State ATEM GIFTS REGISTRY 6-25-0 1 ☐ Burial 2 ☑ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name an Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DLON /Medical resulting in death) Due to (or as a consequence of): Examine Sequentially list conditions, if any, leading to immediate cause. Ener Urbanny Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Box 687606 the attending physician and hed for use as the burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. I 1 ☐ Yes 2 No 9□Unknown 9 Unknown signed by det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by pe 4 ☑Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page this certificate 2 No Division or Vital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 TYes 2 ER/Outpatient 3 DOA Jo 28a. Date of Injury (Month, Day Year) After thi funeral of 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director; ,
completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature title of certifie 29q. Date signed (Month, Day, Year) UNE 2007

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State Registrar 30 Name and

31. Date filed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type

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Registra 's Signature

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State Registrar 3000 D Ventrie Ct Myersville MD 21773

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Yvette Warren

JUN 2 8 2007

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Mic	ir ytaria i		rtificate of l			Reg. No.		_ 0 5 1 1
	Physici	an	1. Decedent's Name (First, Middle, La		7 0	- 1-			2. Date of De	ath Day	Year	3. Time of Death
	/Medic	al	A. C. Maria Maria Maria Maria	Kathryn	A. 5	cnus			June	25	2007	9215PM
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	s 23a	Funeral Dire	9519 Hickory F	Υ				1236		U.S		
	Items Inerr	-une	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 Yes 2 1		13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No o Rican, etc.))-	14. Race - Amei Black, White	
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lar	2 sho and h is ma	•	19a. Informant's Name/Relationship (Type, Print)	1	9b. Maili	ng Address (Street a	and Number or Ru	ıral Route Numbe	er, City o	r Town, State, Z	^{ip Code)} 21236
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Baltimore,	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic a once.		4 □Donation 5 □ Other (Special21. Signature of Funeral Service Lices		Dunm	21	Cemeter Name and Addres	c of Facility				nnsylvania
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	1	ļ	30. Name and address of person who	completed cause of de	eath (tuern 23	a) (Type,	Print)		2 1	1/1	100	42057
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			1- State of Maryland / Department of Hea Certificate of De		,	giene Reg. No.	2017	2007
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	/Medic		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc	cation of Death	0,0,		County of Death	
	Examin	er	Anne Arundel Medical Center Annapolis			1 .	ne Arur	-
_	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If	Under 24 Hrs.	8. Date of Birt (Month, Day	h	9. Birth	place (State or Foreign
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	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					10d. Inside City Limits
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	the h	Director	MD Anne Arunde1 Crownsville 10e. Street and Number 10f. Zip Code			10a. Citiz	en of What Cou	intry?
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	deatl	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispai If Yes, specify Cuban, N	anic Origin? (Spe	cify Yes or No-		4. Race - Amer	
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, maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and a 1028 Miller Cir.					
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	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	29a. Certifier (Check only one) Sertifying Physician: To the best of my knowledge, death occurred at the time, of the companient of the companient of the property of the companient of the companient of the property of the companient of the companient of the pest of my knowledge, death occurred at the time, or companient of the compan	ion, death occurr	ed at the time,	date and	and manner as place, and due	stated. to the cause(s)
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ľ	Sta		31. Date filed (Month, Day, Year) JUN 1 3 2007 32. Pigistrar's Signature Junuary	, , ,	1/0/)	160	
D.	Registr	ar 201	2014 T. 2 COOL DEPART IN TRANSPORT					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physici		Decedent's Name (First, Middle, Last, Harry)	Sa	ackser		2. Date of Dea Month	Day	Year	3. Time of Death
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	Funeral Director		5. Social Security Number 113-07-7512 6. Se	X 7. Age QM 2□F	e (In yrs. last birthday, 89 Yrs.	If Under 1 Year Months Days			,1918	9. Birthp Cour New	place (State or Foreign http:// York
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21215-0036	g c 2	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12	cation le completed) College (1-4or 5	+) (Give	dent's Usual Occup kind of work done DO NOT use retire	during most of wo d)	orking	16b. Kind of Bus		
and 2	should be filed with and Mental Hygiene is marked other the aumatic event, the	To Be Co	17. Father's Name (First, Middle, Last) Louis		Sackser	ail Sales	T	me (First, Middle,	Self E		iyed
Maryland	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 is marke eny injury or other traumatic.	-	19a. Informant's Name/Relationship (7) Barbara Sackser Bl					dural Route Number			Code)
Baltimore,	Pages 1 annent of Hermont: if item		20a. Method of Disposition 1√∑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Disp cometery, cre Mt. Leban	osition (Name of matory or other pla non Cemet	ery 6/1	Date 4/2007	20c. Location - (Adelphi	•	
Balt	permit. Departm importa eny inju		21. Signature of Funeral Service Licens	Homa	De De 2	2. Name and Addre Onald V. 400 Powde	Borgward Mill R	t Funera oad Belt	l Home, sville,	PA Mary	land 20705
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	e. TRICIJUA a consequence of):	or Ar	RHYTH	MID.	rest,		Approximate Interval Between Onset and Death
8760,	certificate be executed rding physician and ise as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	DNAC Y a consequence of):	INCI BL	Y DI.	SEASC			
P.O. Box 68	the death certific y the attending p ched for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3	□Ectopic pregnanc	y		23d. Date Mon		ery Day Year
rds, P	signed be det	ed by PI	Part II. Other significant conditions con	ntributing to death bu	at not resulting in the \mathcal{F}	, ,	ven in Part I.				he cause of death? pably 4 (Unknown
Division of Vital Records,	The law ite has boage 2 st	Somplet						24a. Was autop perfor 1 Yes	med? de	for to co eath?	psy findings available impletion of cause of
/ita	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of De	eath (Check only or			
7	hysi this c	ို	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatie		III SEL DOA		Home 5 Resid			y)
sion o	g te	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injur (Month, Day	Ye <i>ar)</i> Injury	M 1	Yes 2 □No		ow injury occurre		
Divi	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certif	4 ☐ Homicide determined		ry · At home, farm, st . (Specify)			City or Tow			
	the Hosp nin 24 ho the Fune	ledical	(Check only 2 Medical Exami	ner: On the basis of and manner sta		vestigation, in my	opinion, death occ	surred at the time, o	date and place, a	nd due to	o the cause(s)
		Σ	29b. Signature and title of vertifier	MAN N. ATTEND	12 , MD	29c. Licen:		7.	29d. Date signed TUNE	(Month,	Day, Year)
_			30. Name and address of on who co	ompleted cause of de	eath (Item 23a) (Type	SPITAL	MANBE	2 Time	MO 560	Localio.	h Raven Blud. 21239
77	Sta	ite	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	auti)			7		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** STAHL 1139 HAROLD ELMER 06 2007 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Pacility Name (If not institution, give street and number) Examiner Wicomico ALISBURY MEDRIC PENINSULA LENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1**⊠**M 2□ F 148-12-6786 83 **Director** 31 JERSEY Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" ~- "any injury or other traumatic event". 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director VIRGINIA ACCOMACK TEMPERANCEVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29020 23442 USA SAXIS ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 RYes 2 No 1 f Yes, Give 10214 07 1992 Year or Dates: 20 1945 1 Never Married 2 Married Specify: WITTE 1 ☐ Yes 2 🗷 No Š 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry FOOD CANNING Elementary/Secondary (0-12) College (1-4or 5+) 1-ACTORY WORKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GEORGE STAHL MATILDA JURISCH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TEMPERANCE UILLE, VA. 234

Date 20c. Location - City or Town, State LAW 29020 SAXIS ROAD WAYNE REDMAN SON IN 23442 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition CHINCOTENEUE 1 ☐ Burial 2 Cremation 3 ☐ Removal from State ISLAND CREMATURIUM JUNE 16 2007 4 ☐ Donation 5 ☐ Other (Specify) VIRGINIA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility (tox FOX FUNERAL HOME POBOX 278 TEMPERANCEUILLE VIRGINIA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of such line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 240 1 ☐ Yes 2 No 1∏ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: , 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

BH 3+1 State

31. Date filed (Month, Day, Year) JUN 1 5 2007

32. Fegistrar's Signatur

Sperte

Registrar

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		For		State of Ma	arylan					ental Hyg	giene)		
		- State Registrar				<i>C</i>	ertificate o	f Death			Reg. No	<u>-2011]</u>		1081
Physicia	- 1	1. Decedent's Name								2. Date of Dea Month	Day			of Death
/Medic	- 11	Robert	•	Senulis ve street and number)			4b. City, Town	or Location o		June 1	.6,	2007 County of Deatl	-	
Examin	er	310 Gre						alsbu				arolin		
Funeral		5. Social Security No			e (In yrs. i	last birthda	ay) If Under 1 Ye	ar If Under	24 Hrs. 8	B. Date of Birt	h			te or Foreign
Director		173-20-	1073	1 ∑ M 2□F	7	8 Yrs	Months Day	s Hours	Min.	(Month, Day an. 19		929 Penns		
P.	İ	Usual Residence of			10a Cita	. Taura as	Leastion							
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leath ns 23 must	era	11, Marital Status	CIIIII	12. Was Decedent	Ever in U.	S. 1	3. Was Decedent of If Yes, specify C		igin? (Spec			14. Race - Amer		,
ifter d r iten niner	필	1 ☐ Never Marri	ed 2K Married	Armed Forces? 1 □ Yes 2 □ I If Yes, Give	No					ican, etc.)		Black, White		
urs a al", o Exan	by	3 Widowed	4 ☐ Divorced	If Yes, Give Year or Dates:	47-	-51	1 ☐ Yes 2 ☒ N	lo Specify:				Specify: Wh	ıte	
72 ho natur dical	Completed	(Spec	15. Decedent's E	Education rade completed)		16a. De	cedent's Usual Occ ive kind of work doi e. DO NOT use ret	cupation ne during mos	st of working		16b. K	ind of Business/l	ndustry	
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d be fantal H	To Be (lis, Sr.						elski		, our name)		
should be filed within 72 hours after death with the Maryland not Mental Hyglene. In arked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	۲	19a. Informant's Na				19b. Ma	ailing Address (Stre					or Town, State, 2	ip Code)	
nd 2 stath art 27 is				ulis/Spouse	9		Greenrid							
s 1 ar f Hea ltem	İ	20a. Method of Disp	osition				sposition (Name of crematory or other p		Da			ocation - City or		1
permit. Pages I and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			□Cremation 3 [5 □ Other (<i>Sp</i> ec	☐Removal from State ify)			of Lourdes		June 19	, 2007 I	31a	des, I	elaw	are
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a in Dec		Chri	otine	m. Coa	le	4	216 N. Ma	in St.	, Fed	eralsb	urg,	MD 216	32	
19		23a. Part1, Enter the shock, or hear	ne disease, or cor rt failure. List onl	nplications that caused y one cause on each li	the death	h. Do not	enter the mode of o	dying, such as	cardiac or	respiratory ar	rest,		Approxi Interval	Between
Physician		Immediate Cause (disease or condition	Final	a CONG	E51	IVE	HEAL	ZT FI	HLU	RE			Diset a	nd Death
/Medical Examiner		resulting in death)	-	Due to (or as	a conseq	uence of):					0.5		77	
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The law requires that the death certificate Late has been signed by the attending physic bage 2 should be detached for use as the b	Physician/Medical													
h cer endin	N/UE	IF FEMALE: 23b. Was decedent		23c. If yes, outcome 1□Live birth	pf pregna		3 □Ectopic pregna	incv				23d. Date of deli		
deat he atte	sicia	in the past 12 1 ☐ Yes 2 ☐		4☐Pregnant a 9☐Unknown			5 ☐ Other (specify,					Month	Day	Year
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Phys r this ral di	٦.	1 Yes 2 ☐ 27. Manner of Deat		28a. Date of Inju		28b. Tim	HOIL OF BOX	jury at Vork?		e 5 Resid		6 □Other (Spec	cify)	
tding th. : Afte fune	tion	1 XNatural 2 ☐ Accident	5 ☐ Pending investigation	(Month, Da	y Year)	Inju		Vork? □Yes 2□				,		
Atter r deal ector by the	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	2 Zoe, Flace of III]	ury - At ho	ome, farm,	street, factory, offi	ce	28			nd Number or Ru	ıral Route I	lumber,
al or s after al Dir	Certification:	4 Horricide		building, et	с. (эресп	у)				City or Tov	vii, State	θ)		
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only		Physician: To the best										(e)
the H nin 24 the F	Medical	one)		and manner st		مندا . (-								
Vith Vith Con Con Con Con Con Con Con Con Con Con	2	29b. Signature and	title of certifier		DE	YUTY	29c. Lice	ense number	11.		29d. Da	ate signed (Monti	n, Day, Yea	007
		Chul	au the	WHEN /1/1)	/1/	E		406	1			0111	120	10/
		30. Name and addr	ess of person wh	completed cause of d	leath (Iten	D Ty	Print ()	DENT	700	MD	21	639		
Sta	te	31. Date filed (Mon	th, Day, Year)	32. Registr	ar's Signa	ature	11.010 /=		UII 1	1111	6-1			
Registr	-		JUN 1 9	2007	ann	1.3	Prost o							
				- April - Apri	1	401	17.7							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 12:15 AM June 14 2007 Raymond Leslie Smith /Medical 4c. County of Death Examiner 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Genesis HealthCare - The Pines Talbot If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year)
June 29, 1 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 M 2 F Yrs. 1923 Vi<u>rginia</u> Director 226-18-1373 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or Itama 23a or 28a-f show the Medical Examiner must be notified at 1√ Yes 2 No Maryland | Queen Anne's <u>Oueen Anne</u> Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States of America 13706 Main Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 10 Baltimore, Maryland 21215-0036 Specify: Caucasian 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) Lumber Company Sawyer other treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 2 John Francis Smith Lora Alice Rhodes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important; if item 27 is eny injury or other treu once. PO Box 174, Queen Anne, Maryland 21657 Wife Betty L. Smith 20b, Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, Slate Maryland Eastern's Shore 1 Burial 2 □ Cremation 3 □ Removal from State 4 □Donation 5 □ Other (Specify) Veterans' Cemetery 6/18/2007 Beulah, Maryland Name and Address of Facility
Moore Funeral Home, P.A. gnatur of Funeral Service License 12 South Second Street, Denton, Maryland 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1020 Dusto (or as a consequence of): /Medical **Examiner** Nan Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed anding physicien and use as the burial-transit o as a consiquence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 es 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 2 1 No certificate 1 Yes After this certification, funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ☐ No 4 Hursing Home 5 Residence 6 Other (Specify) Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pendina 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director; / completely filled in by the f 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospitel 29a. Certifier 1 🖰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and litle of certifier en 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 804 ROBINS

Registrar

DHMH 17 Rev 1/2001

State

Smith

Raymond

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 12:25 am 2007 Roy R. Torcaso June 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 17234 New Hampshire Avenue Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days 1**X** M 2 □ F 051-70-0921 Nov. 13, 1910 Washington Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10h Counts 1 ☐ Yes 21 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 20905 17234 New Hampshire Avenue United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 🛣 No Specify: ģ White WWII 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Torcaso Cathryn White ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. Torcaso/Son 20 Seagrave Road, Cambridge, MA 02140 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 6/19/2007 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or leart failure. List only one cause on each line. Immediate cluse (Final disease or condition resulting in death) a. Metastatic Prostate Cancer Approximate Interval Between Onset and Death 10-15 yrs Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Sick Sinus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Pacemaker 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an 2 700 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Physician: The law requires that the death certificate be executed and burial-trar P.O. Box 68760, Division or Vital Records, Hospital or Attending Director: within 24 hours a

Torcaso, Koy

Physician /Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ---- any injury or other traumatic everal.

Medical Certification: To 28a. Date of Injury (Month, Day Year) 1 Natural 5 ☐ Pending investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier

28c. Injury at Work? 1 □ Yes 2 □ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

title of certifier 29b. Signature an 30. Name and address of person who completed

D31001

29c. License number

29d. Date signed (Month, Day, Year) 6/11/2007

cause of death (Item 23a) (Type, Print) 7500 Greenway Cntr. Dr. #430 Greenbelt,

State Registrar

completely

10+1

2

31. Date filed (Month, Day, Year) JUN 14

(Check only one)

Turkewitz 32 egistrar's Signature

MA

			Please	Type or Prin State of Ma							egible.		
			For State Registrar	State of Ivia	iyiaiic		rtificate of L		, ,	Reg. No.	007	200	033
19 P	Dhymini		1. Decedent's Name (First, Middle, La						2. Date of Dea	- 00	Year	3. Time of	Death
	Physicia /Medic		Lillian	н.		Tweedy			June	9,	2007	5:39	P M
	Examin	er	4a. Facility Name (If not institution, given Shady Grove Hospi				4b. City, Town, or Rockville	Location of Death		4c. C Mc	ounty of Death ontgome	ry	
	Funeral Director		230-40 0402		(In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 1-13-1	v. Year)	9. Birth Cou Casc	place (State ontry) ade, V	or Foreign A
	Maryland -f show iied at	tor	Usual Residence of Decedent 10a, State 10b, County VA Prince V	Villiam		Town or Lo	cation					10d. Inside C	ity Limits 2 No
	h with the 23a or 28a st be notif	al Director	10e. Street and Number 9747 Zimbro Avenu	ıe			10f. Zip Code	20110		10g. Citize Unite	on of What Cou	ntry? es	
2-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Married 2 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 3 V If Yes, Give Year or Dates:			Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-		. Race - Ameri Black, White pecify: Bla	etc.	
212-0	thin 72 ho e. an "natur Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-	+)		dent's Usual Occupa kind of work done of DO NOT use retired,		king		of Business/li	ndustry	
and 21		Be	12 17. Father's Name (First, Middle, Last Samuel H. Hairst			Publi	c Service	18. Mother's Nam	e (First, Middle, Wilson		Hall urname)		
Maryle	s 1 and 2 should be f Health and Menta Item 27 Is marked other traumatic ev	70	19a. Informant's Name/Relationship (Charlene T. Phill		ter)		ng Address <i>(Street &</i> Zimbro A		ral Route Numbe	-		o Code)	
baltimore,	permit. Pages 1 and Department of Health Important; If Item 27 any Injury or other to once.		20a. Method of Disposition 1 Burial 2 Cremation 34 4 Donation 5 Other (Special Signature of Funeral Service Accessions)	Removal from State	20b. Pla	ace of Disponmetery, crei	esition (Name of matory or other place Memorial 2. Name and Addres 01 Bladen	e) Park 6/1 s of Facility Fo	0/2007 rt Linco	20c. Loca Roan oln F	oke, VA	Home	
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	plications that caused one cause on each line a	e. A consequ ON	Do not ent				rest, -	.,	Approxima Interval Be Onset and	te tween Death
68/60,	eath certificate be executed attending physician and for use as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to for as a	Consequence of the consequence o	ence of):	Mess	iris	Rpe	à		yen yen	75 18
O. Box	law requires that the death certificate be as been signed by the attending physicia 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome p 1 Live birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3[⊒Ectopic pregnancy □ Other <i>(sp</i> ec <i>ify)</i>			23	d. Date of deli Month	-	Year
cords, P.	siclan: The law requires that the de certificate has been signed by the rector, page 2 should be detached	by	Part II. Other sig ficant conditions	contributing to death bu	it not re	Iting in the u	nderly g cause give	en in Part	23e. Did to	Yes 2□	e contribute to No 3 Pro 24b. Were aut	bably 4	Unknown
Ŭ	The ate his page	Completed	- OHECID	-5/_)					autor		prior to c death? 1 \(\sum Yes \)	opsy findings ompletion of c	ause of
25. Was case referred to medical examiner? 1 Yes 25 No. 25 No. 26 Place of Death (Check only one) 26. Place of Death (Check only one) 27. Manner Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred													
0	hysik this ca il dire	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatier			nt 3 DOA Othe	4 Li Nursing H	ome 5 Resid			ify)	
	ng Phys ifter this	:uc	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day		28b. Time o Injury	f 28c. Injun Work	/ at </td <td>28d. Describe h</td> <td>now injury</td> <td>occurred</td> <td></td> <td></td>	28d. Describe h	now injury	occurred		

Division

To the Hospita or Attending P within 24 hours after death.
To the Funeral Director: After t Medical Certification 3 ☐ Suicide 4 ☐ Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. and address of person who completed cause of death (Item 23a) (Type, Print)

AND CONTROL OF CONTROL

32. Registrar's Signature

N 1 3 2007 31. Date filed (Month, Day, Year)
JUN 1 3 2007

5 Pending investigation

1 Natural

2 Accident

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State	of Marylar	-	irtment tificate			ınd M	_	giene Reg. No:	007	2098 ;
ľ			1. Decedent's Name (First, Middle, Las	st)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physici: /Medic		William Charles	Trail							June 2	20, 2	2007	1348 "
	Examin		4a. Facility Name (If not institution, give	street and no	umber)		4b. City,	Town, or	Location o	f Death		4c.	County of Deat	h
			Garrett County N	1emoria	1 Garde	ns	0ak	land					Garrett	
	Funeral		Social Security Number 6. S		7. Age (In yrs.		If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	9. Birt	hplace (State or Foreign
	Director		213-20-3310	∑ M 2□ F	75	Yrs.					Nov.		931 Mai	ryland
	pu *		Usual Residence of Decedent 10a. State 10b. County		10c C	ity. Town or Lo	cation							10d. Inside City Limits
	anyla shon	_				•	Cation							1 ☐ Yes 2 X No
	89-f	Director	MD Garret	<u> </u>		CHenry	1404 71					40- OH	zen of What Co	
	vith th	盲	10e. Sfreet and Number				10f. Zip							,
	ath v	rai	343 Bumble Bee 1			10 100		1541		. 0.40			nited St	
	er de	Funeral	11. Marital Status	Armed F	orces?	J.S. 13. 1	Mas Deced f Yes, spec	ent of Hi	n, Mexican	gin? (Spe i, Puerto l	cify Yes or No Rican, etc.))-	Black, White	
9	s aft	by F	1 ☐ Never Married 2 2 Married 3 ☐ Widowed 4 ☐ Divorced	I VAS G	2□No live Dates: Kore		I □ Yes 2	2 X No	Specify:				Specify: Wh:	íto
9500-61212	hou		15. Decedent's Ed		Dation KOLE	16a. Deced	ient's Usua	J Occupa	ation			16b. Kii	nd of Business/	
Ċ	in 72	Completed	(Specify only highest gra	de completed		(Give	kind of wor DO NOT us	k done o	<i>turing</i> most	t of workii	ng	100		,
7	with than than	E	Elementary/Secondary (0-12)	College	(1-4or 5+)	worl	ker					We	estingh	ouse
	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "netural", or items 23a or 28a-f show avent, the Madical Examinar must be notified at	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle	, Maiden	Sumame)	· · · · · · · · · · · · · · · · · · ·
Maryland		To B	William H. Trai	1					Tere	sa M	. Apple	ebee		
چ	2 should be and Menta is marked sumatic av	-	19a. Informant's Name/Relationship (Type, Print)		19b. Mailir	g Address	(Street a					r Town, State, 2	Zip Code)
	and 2 Belth a m 27 is		Mrs. Constance	Frail,	Wife	343	Bumb:	le B	ee Rd	., M	cHenry	, MD	21541	
<u>6</u>	一至重要		20a. Method of Disposition		20b.	Place of Dispo	sition (Nam	ne of	e)	D	ate	20c. Lo	cation - City or	Town, State
Ê	Pages nent of int: If it iry or o		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		n State [rrett l				6/2	3/07	0ak1	land, M	D
altimore,			21. Signature of Funeral Service Licer	-	, 00								ne, P.A	
ñ	permit. Depertr Imports any inj		* Katherine	10000			21 N.	d A.	Burd	ock St.	Tunera. Oaklan	l Hon	ne, P.A D 21550	•
			23a. Part1. Enfer the disease, or com shock, or heart failure. List only	plications	caused the dea	ith. Do not ent							21550	Approximate Interval Between
	Dhualaina		Immediate Cause (Final	one cause on	each line.	5	^							Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	(or as a conse	7 190	hen	uc		vec	412			H Ckeys
	Examiner			A	illeri	0 11	Low	260	· Dor	r9-1's	11			Wears
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	o (pr s/a conse		VUELE	150						7
	uted ansit	E	cause. Enter Underlying Cause (Disease or injury that inifiated events											
ĵ	n an ial-tr	Examiner	resulting in death) Last	Due to	(or as a conse	quence of):				_				
8760	cate be executed physicien and the burial-transit	dicai		_d										
9		0												
ROX	eath certifi attending (5	IF FEMALE: 23b. Was decedent pregnant		utcome of pregr		Ectopic pr	ago an ou					23d. Date of de	,
	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		gnant at fime of		Other (sp						Month	Day Year
J.	that the de led by the a deteched t	hys	9 Unknown	9LI UNK	nown						1	1		
_	res tha iigned be del	by Physician/M	Part II. Other significant conditions of	contributing to	death but not re	/	- I i	-			23e. Did t	tobacco u	ise contribute to	the cause of death?
ğ	w require been sig should b	ed	rypertiens	ou,	regio	nipi	alev	nea	J		10	Yes 2	No 3□P	robably 4 Unknown
Records,	aw requisite per per per per per per per per per pe	piet	01		01	•					24a. Was		24b. Were at	utopsy findings available completion of cause of
	The law requires that the death certifi tie has been signed by the attending page 2 should be deteched for use as	Completed										ormed? 2 2 No	death?	2 □ No
Vital		0	25. Was case referred to medical				,		26. Place	of Death	Check only	1		
	Physici this cer al direc	To B	examiner? 1 Tes 25 No	Hospital:	Inpatient 20	☐ ER/Outpatier	t 3 DO	A Oth	er: 4 □ Nu	ırsing Hor	ne 5 🗀 Resi	idence	6 □Other (Spe	icify)
to c	Attending Physician: or death. actor: After this certific by the funeral director,		27. Manner of Death	28a. De f	e of Injury onth, Day Year)	28b. Time o	2	Bc. injun	at c?	:	28d. Describe	how injur	y occurred	
Ö	ath. r: Af	atio	1 Accident 5 Pending investigation	n	,	,,	М		Yes 2□	No				
Division	Atta	₽	3 Suicide 6 Could not b	200. F W	ce of Injury - At I	home, farm, str	eet, factory	, office			28f. Location (City or To	Street an	d Number or Ri	ural Route Number,
Ξ	s aft	Certification:											<u></u>	
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the ft	Medicai	29a. Certifier Certifying Pl	niner: On the	basis of examin	nowledge, deat ation and/or in	n occurred vestigation,	at the tim	ne, date an pinion, dea	d place, a	and due to the	cause(s)	and manner as	s stated. to the cause(s)
	tha hin 2 tha mplet	Med	one)	and ma	nner stated.	/	200	License	e number			304 Dat	te signed (Mont	th Day Veerl
	T w C O		29b. Signatule and title of certifier	- 1	1/	1	1 230	7)	Talak	20			-	
			rungavet	u	4 su	urk	0)	V	00	0		6	ou i	aco 1
			30. Name and address diperson who	completed ca	use of death (Ite	m 23a) (Type, 3019 A	Print)	-1.	0		abli		111	2007
			31. Date filed (Month, Day, Year)	22	Registrar's Sign		LW EU	Mis	rura	4	CERT	inel	, rra o	1/550
	Sta Registi		JUN 2 2	2007	200000	Ac	Conti		•	•				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Dav Year **Physician** 1630 Ventura 2007 Marcos 06 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Baltimore if Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Min 1**X**M 2□ F Months Days Hours 81 64162 4675 October 7,1925 El Salvador Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at ty∏Yes 2 No Director Maryland | Prince George Hvattsville 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code El Salvador 20783 7110 24TH Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Yes 2□ No Specify: American Indian Specify: Salvadorian If Yes, Give Year or Dates: þ 31☑Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 6 TH other than College (1-4or 5+) Landscaping, INC. Landscaping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f end Mental I Brigida Melendez is merked Jesus Ventura 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlos Alberto Ventura permit. Pages 1 and 2:
Department of Health er
Importent: If item 27 is
any Injury or other trau 1606 Sagebruhs Court, Severns, MD. 21144 20b. Place of Disposition (Name of cemetery, crematory or other place)
Nance Dulce Cemetery June 17,2007 20c. Location Ety of Town State or 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Aguas Calientes, Union 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Santa Cruz Funerales Latinos, INC 21. Signature of Funeral Septice Licensee 600 Kennedy St, N.W.Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pancreatitis Due to (or as a consequence of): necrotizina disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the buriel-transit the death certificate be executed Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the at d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ compartment 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed abdominal 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an metabolic acidosis autopsy 2 No or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA ပ္ this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural Injury 5 ☐ Pending investigation 1 TYes 2 TNo ours after death.
neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of codifier 29c. License number 29d. Date signed (Month, Day, Year)

(2)

State Registrar Alissa Dangel - University

31. Date filed (Month, Day, Year)

JUN 13 2007

JUN 13 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

16544

06

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Year PAUL Ε. VOUGHT 06 07 21 2240 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner WMHS BRADDOCK CAMPUS **CUMBERLAND** ALLEGANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) 8/1/1923 9. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Days 1**X** M 2 □ F 83 192-12-3848 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside Cify Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at PA 1 ☐ Yes 2 No Somerset Co. Directo Meversdale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 221 Yoder Rd. 15552 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12. Ves 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: White 3
☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Carpenter 12 Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Vought Carrie Engle ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 is any Injury or other trau Carrie J. Miller 221 Yoder Rd., Meyersdale, PA 15552 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 Removal from State Union Cemetery 6/25/2007 Meyersdale, PA 15552 4 Donation 5 Other (Specify) 22 Name and Address of William Rowe Price Funeral Home, Inc 21. Signature of Funeral Service Licenses CC0376 325 Main St., Meyersdale, PA 15552 23 art1. Enter the disease, or commercations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic **Physician** Cardiovascular 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 2 1 Inpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Worsocheften MD 00055325 June 12, 2007 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VA 48 Tarn WONSOCK SHIN MD Terrace Frostburg MD 21532 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 5 Registrar

			for State Registrar	State of Marylar	•	rtificate of		менкан пу	Reg. No	C	21	0.97
	Physici	ian	1. Decedent's Name (First, Middle, La	st)				2. Date of Do	eath Da	y Year	3. Time of	
W 49	/Medic		Thomas Eugene					June 8	3	2007		P ^M
	Examir	ner	4a. Facility Name (If not institution, giv	·			r Location of Death	1		County of Deat		_
1000000			Southern Maryl 5. Social Security Number 6. S	and Hospital Sex 7. Age (In yrs.		Clinto		8. Date of Bi		rince (
	Funeral Director			1□ M 2 1 69	Yrs.	Months Days	Hours Min.	Mar. 2	ay, Year,	938 DC	nplace (State ountry)	
/land	ow		10a. State 10b. County	10c. Ci	y, Town or Lo	cation					10d. Inside C	ity Limits
Man	a-f sh ified	tor	MD Prince	Georges Ca	pitol	Height	s				1 Yes	2 □ No
th the	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Ci	tizen of What Co	untry?	
ath wi	23a ust b	ral	5634 Malvern	Way		20743			USA			
er de	tems ner m	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No o Rican, etc.)	0-	 Race - Amer Black, White 		
Z1215-0036 d within 72 hours after death with the Maryland	ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medikal Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 █ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No if Yes, Give Year or Dates:		1□Yes 2XINo					lack	
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	Hygi other ent, t		17. Father's Name (First, Middle, Last		Lege	AT DOLVE	18. Mother's Nam	ne (First, Middle	-			
id be		To Be	Thomas West				Bernic	e Jose	ephi	ne		
i, Maryiand and 2 should be file	f Health and Mer item 27 is marke other traumatic		19a. informant's Name/Relationship (Thomas Eugene	**	19b. Mailin 3632 Wash	2 13th S	and Number or Ru St., NW	ral Route Numb	per, City	or Town, State, Z	ip Code)	
s 1 a	item item othe		20a. Method of Disposition	20b. I	Place of Dispo	sition (Name of matory or other place	ce)	Date	20c. L	ocation - City or	Town, State	
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Baltimore , permit. Pages 1 ar	Department Important: any injury once.		21. Signature of Funeral Service Lice		22 N	Name and Addre	ess of Facility S Fune 1 Street	ral Ho	ome,	Inc.		011
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/	Medical		disease or condition resulting in death)	Due to (or as a consec	uence of):	(0) 4		20.00	.,,	1		
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68/60, tificate be executed	ig phys as the	ledical		d								
	attending for use a		iF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregn	ancy	7-				23d. Date of deli	very	
. ö	d for	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Feta 4□Pregnant at time of o		∃Ectopic pregnanc _? ∃Other <i>(sp</i> ec <i>ify)</i>	y —			Month	Day	Year
at the	been signed by the should be detached	hys	9 ☐ Unknown	9□Unknown								
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OF Phys	.일 모	임	17 Yes 2 No 27. Manner of Death		ER/Outpatier		4 ☐ Nursing H			6 ☐Other (Spec	cify)	
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DIVISION I or Attending	death.	icat	3 ☐ Suicide 6 ☐ Could not b	e 28e Place of injune At h	ome, farm, str		1163 2 110	28f. Location	(Street a	nd Number or Ru	ral Route Nun	nher
5 0	after I Dire d in b	Certification:	4 ☐ Homicide determined	building, etc. (Special	(y)			City or To	wn, Stat	e)		,
L Hospital	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier 1 Certifying Pl (Check only one)	hysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the ti vestigation, in my	me, date and place opinion, death occu	, and due to the	e cause(s , date an	s) and manner as nd place, and due	stated. to the cause(s)
To the	within To the comple	Me	29b. Signature and title of certifier	1.	-	29c. Licens				ate signed (Monti		
0 /	2		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type,	Print)	53200	1	0	-8-0 d 20	/	
4	>/		Wendell Pierso	nMO 7503		atts ho	ad Chi	aton	M	d 20	735	
	Sta Registi		31. Date filed (Month, Day, Year) JUN 1 4 2007	32. Registrar's Signa	ature							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) 06/07/2007 MARY ROBERTA WESLEY 1800 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PRINCE GEORGE'S FORESTVILLE FORESTVILLE MILLINIUM NURSINGHOME | Hunder 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 9/23/1948 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 ☐ M 2 🕅 F DISTRICT OF COLUMBIA 58 577-66-6577 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No PRINCE GEORGES FORESTVILLE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES of AMERICA 20747 #201 3223 WALTERS LANE 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 Nivorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MARYLAND UNIVERSITY EXECUTIVE SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) LEONA MAE PORTER WILLIE HARPER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3223 WALTERS LANE FORESTVILLE MD, 20747 GREGORY SIEELE/ FRIEND 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State JUNE 15, 2007 CLINION, MD RESURRECTION CEMEIERY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility MURRAY FUNERAL HOME 21. Signature of Funeral Service Licen 4804 GEORGIA AVE. N.W. WASHINGTON DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CANCER OF BREAST WITH BRAIN METASTASIS Due to (or as a consequence of) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to for as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 √2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 2 X No 25. Was case referred to medical examiner? 26. Place of Death Check onl. one Hospital: Cther: 4 1 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ XNo 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Completed by Funeral

Be

2

i Health and Mental Hygiene. itam 27 is marked other than "natural", or Items 23a or 28a-1 shov other traumatic avant, Tha Medical Exama actinual be rediffed at

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permit. Page Department of Important: If any injury or once.

the Maryland

WIT

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

Examiner attending physician and for use as the burial-tran Physician/Medical ģ by Completed page 2 Be 2 this Certification: After death.

that the death certificate be executed Box 68760. P.O. Division of Vital Records, Physician: Hospital or Attanding after death filled in by the 24 hours a pletely tha the

	7 wit
CR.	6
	St

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAHRAM PISHDAD 31. Date filed (Month, Day, Year) ate JUN 1 4 2007

29b. Signature and title of certifier

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

Medical

4 T Homicide

5 Pending investigation

6 Could not be

determined

1328 SOUTHERN AVE. S.E. #310 WASHINGTON DC, 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 51520

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6/11/2007

29d. Date signed (Month, Day, Year)

20032

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physici	an	Decedent's Name (First, Middle, Last)	Jeiny	210 6				2. Date of Dea Month	Day Year	
à	/Medic Examin		4a. Facility Name (If not institution, give s		1	4b. Ci	ty, Town, or Loca	ation of Death	Jun	6 200'	/
			Seburban A	109pito	/	1		es Va		mon	Tromery
	Funeral Director		5. Social Security Number 6. Sex 093-07-4481	7. Age	(In yrs. last bi	Yrs. If Und Month		Jnder 24 Hrs. ours Min.	8. Date of Birts (Month, Day	y, Year)	(thplace (State or Foreign Country)
			Usual Residence of Decedent		71	110.			10/21/1	1915	NEW YORK
	anylan show	<u>.</u>	10a. State 10b. County		10c. City, Tow						10d. Inside City Limits
	the M	ecto	MARY LAND MONTGOM	ERY	ROCKVI		Zip Code			10g. Citizen of What C	M☐Yes 2☐No
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	eme 2	ner		2. Was Decedent E Armed Forces?	ever in U.S.	13. Was De	cedent of Hispan pecify Cuban, Me		ecify Yes or No-		rerican Indian,
36	within 72 hours atter death with the Maryland ene. Than "naturel", or iteme 23e or 28e-f ehow ta Madical Exartater must be notified at	by Funeral Director	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	1 ☐Yes 2 ☑N If Yes, Give	lo		12	ecity:	riouri, Sto.)		WHITE
9	2 hour	ted t	15. Decedent's Educ	Year or Dates:	16a	. Decedent's U	sual Occupation			16b. Kind of Busines	s/Industry
2	ithin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5-	+)	(Give kind of life. DO NO1	work done during use retired)	g most of worki	ng		,
7	filed w Hygien other th	S	12 17. Father's Name (First, Middle, Last)			S	ECRETARY		(C) 8.8°	HEALTH	CARE
and	ld be f lental h ked of Ic eve	To Be	MAX ROSENTHAL					LARA ME		Maiden Sumame)	
Maryland 21215-0036	nit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan ertiment of Health and Mental Hydione. ertiment of Health and Mental Hydione. ertiment of Health and Mental Hydione. njury or other traumatic event, the Maritsal Expiration must be notified at a number of the modified at the modified of the modified at the modified a	-	19a. Informant's Name/Relationship (Typ							or, City or Town, State,	
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.O. Box	that the death certift ed by the ettending detached tor use as	Physician/Me	in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth = 2 4 ☐ Pregnant at t	2 Fetal death	3 ☐Ectopic				23d. Date of de Month	elivery Day Year
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Division of Vital Records, F	8 8 8	۾	Part II. Other significant conditions con Atrial Fibril	tributing to death bu	t not resulting i	n the underlying	g cause given in I	Part I.		obacco use contribute es 2 No 3 F	to the cause of death? Probably 4 Unknown
eco	e law requir has been si je 2 should l	Completed	Fractures of the should	der and elbo	DW WC				24a. Was a	an 24b. Were a	autopsy findings available ocompletion of cause of
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\frac{1}{5}	Attending Physician: r death. setor: After this certition by the tuneral director,	To Be	25. Was case referred to medical examiner? 1 🗓 Yes 2 🗆 No	ospital: 1 Anpatier	2 DEB/O	utpatient 3	Other		(Check only or		
פֿר	ding Phy h. After thii tuneral c		27. Manner of Death	28a. Date of Injury (Month, Day	y 28b.	Time of Injury	28c. Injury at Work?			lence 6 Other (Sp low injury occurred	ecity)
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	1		Manual M	D			D006011			June 6, 2	
	- 1		30. Name and address of person who con	npleted cause of de	ath (Item 23a)	(Type, Print)	2-1	100 CC	050		
	- C		E.D. Park MD 9901 31. Date filed (Month, Day, Year)		r's Signature	4		MD 208	850		
	Sta Registr		JUN 1 4 2007	Maria	K	South)	1				

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AMEND TIEM#7,8, perFH, G868,6/29/07, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 🦾 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day JUNE 27, HATTIE BELL ALLEN 2007 9:20a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3409 MONDAWMIN AVE. BALTIMORE N/AIf Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 🗓 F Director 228-12-9364 86 -87 2-18-1920 VIRGINIA Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 XYes 2 No MD. BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3409 MONDAWMIN AVE. 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: **BLACK** þ 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -10--0-NURSING ASSISTANT HEALTHCARE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) DAVID BALLOU FANNIE TUNE 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trauonce. ROSE BOLDEN(SISTER) 4552 DERBY MANOR DR. BALTIMORE, MARYLAND 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation ☐Removal from State 4 ☐Donation ☐ Other (Specify) ARBUTUS MEMORIAL PARK 7-3-2007 BALTIMORE, MARYLAND 21. Signature of Funeral Safvic Lid nsee ON ATHAN HIBN R. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. D: 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, dyneart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Myocardial Infurction

a.

Myocardial Infurction Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Mellim Diabeto Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ M6 24a. Was an autopsy performed? 2 10 No 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

The law requires that the death certificate be executed burial-Box 68760, physician s the burial attending pl for use as t Division or Vital Records, P.O. this I or Attending Fafter death. Director: filled in by To the Hospital of within 24 hours af To the Funeral D

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death

and Mental

Baltimore, Maryland 21215-0036

28a-f show

ral", or items 23a or 28a-f shov Examiner must be notified at

'natural", or

7 is marked other than traumatic event, the Me

State Registrar

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Khande (Wal M)

9

Mile

DHMH 17 Rev 1/2001

3001,

Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0052440

S. Hanzver St. Baltimore

MD 21227

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. 3 per doc 8869 7-11-07 vt State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** am 9:307 June 24 2007 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner toward Huspital Columbia umard ount If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**∑X**M 2□ F Months 71 Director 493-40-7138 08/25/1935 MO Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show if of Health and Mental Hygiene.
If item 27 Is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4945 Columbia Road Apt. H 21044 USA Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) TWA Elementary/Secondary (0-12) College (1-4or 5+) Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Roscoe Anderson, Sr. ည Frances Edwards 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris Anderson/Wife 4945 Columbia Road Apt. H Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jun 28 Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory Inc. 2007 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Alternatives 0) 8717 Green Pastures Drive Baltimore Maryland 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** en tricular minute /Medical Due to (or as a consequence of) Examiner SCVD Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-trar Due to (or as a consequence of): physician Physician/Medical the attending p as IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖼 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ned by the a e detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be c Completed by 2 No 3 Probably 4 Whinknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? 2 Be Medical Certification: To this funeral After

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, after death the filled in by within 24 hours a

To the Funeral I

completely filled To the Hospital

							1□ Yes	2 N O	1 ☐ Yes	2 🔀 No	
25.	Was case referred to medical		26. Place of Death (Check only one)								
	examiner? 1	No	Hospital: 1 ☐ Inpatient 25	ER/Outpatient	3□ D	OA Other: 4 Nursing	Home 5 ☐ Resid	dence 6	□Other (Spec	ify)	
27.	Manner of Death 1 Matural 2 Accident	5 ☐ Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe I	now injury	occurred		
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of injury - At h building, etc. (Spec	nome, farm, stree sify)	t, facto	ry, office	28f. Location (3 City or Tox	Street and vn, State)	Number or Rui	ral Route Number	Ç,
29	a. Certifier (Check only		nysician: To the best of my kn niner: On the basis of examin								

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

00038026 of person, who completed case of death (Item 23a) (Type, Print) Cedar Lane Columbia

State Registrar

12

31. Date filed /Month Day. Year) 9

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07-04778 Ве

-04778 enjamin Asher		State of Ma	ryland / Depar					510.	
•		- For State		ificate of			Reg.	No.	
Physiciar edical Examin	n/ 1 er	Decedent's Name (First, Middle,Last) Benjamin	Ashe				2. Date of Death Month D June 23, 200		3. Time of Death 1135 hrs
, 0.1-1	4	 Facility Name (it Not institution, give street a Baltimore Washington Medical C 	enter		Glen Burnie			4c. County of Deat	1
Funeral Director	4	5. Social Security Number 6. Sex 12 1 - 08 - 4753 1 1 1 1 1 2	7. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth(Fore	rthplace (State or gn ountry)
ow any.		Usual Residence of Decedent 10a. State 10b. County	1 1	Town or Location	n				10d. Inside City Limits 1 Yes 2 No
he Maryland or 28a-f show ified at once.	91	10e. Street and Number 8818 Haw Horne	Ln. Apt	.72	10f. Zip Code	708	10g.	. Citizen of What Co	untry?
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once	- L	11. Marital Status 1 Never Married 2 Married 1 Arri		If Ye	Decedent of Hisp es, specify Cuban,	anic Origin? (Sp Mexican, Puerto		White, etc.	rican Indian, Black,
hours after 'natural'', o	습.	3 Widowed 4 Divorced or Date: 15. Decedent's Education (Specify only higher Elementary/Secondary (0-12) Col	·	16a. Decedent	Yes 2 No 's Usual Occupation st of working life.	on (Give kind of v	work done 1 red)	Specify: 6b. Kind of Business	s/Industry
1215-0036 d'be filed within 72 hours ar fental Hygiene narked other than "natural event, the Medical Examin	Completed	17. Fatter's Name (First, Middle, Last) A		Com	outer E	pecial 8 Mogner's Name	First, Middle, Ma	topulati	on Action
e, MD 21215-0036 I and 2 should be filed within 72 Health and Mental Hygiene item 27 is marked other than r traumatic event, the Medical	Be	Oames H. Hish 19a. Informant's Name/Rylationship (Type, Pri		19b. Mailing		and Number or	Rural Route Numb	er, City or Town, Sta	
and and lealt tem		Kendra Hsher (1 20a. Method of Disposition			tion (Name of cerr			20c. Location - City	_
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Balt Bermit Depart Import	1	23a. Part Enjer the disease, or complications failure. List only one cause on each line.	that caused the death.	51s	SI BUTO	Nat'l P:	or respiratory arres	more, mb	Approximate Interval Between Onset and
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	iner	Sequentially list conditions.	tensive Atheroscl or as a consequence of		ovascular Dis	ease	-		
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Sox 68760, leath certificate be attending physici for use as the buri	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9	If yes, outcome of preg Live birth Pregnant at time of de Unknown	2 Fe	tal death 3 her (Specify)	Ectopic pregn	ancy	23d. Date of deliv Month	ery Day Year
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Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could not be determined (3	se. Place of Injury - At h				or Town, St	ate)	Rural Route Number, City
To the Hos within 24 hv To the Fun completely	Medical (29a. Certifier (Check only) one) 2 Medical Examiner: On the and m	the best of my knowled basis of examination a anner stated.	lge, death occu and/or investiga	tion, in my opinior	n, death occurred	nd due to the cause I at the time, date a	and place, and due to	the cause(s)
F 3 H 8	Me	29b. Signature and title of certifier	Hall	al	29c. Licens O.C.			29d. Date signed (
15		30. Name and address of person who comple Carol Allan, MD Assistant Mo	ted cause of death (Iter edical Examiner	n 23a) 111 Penn	Street, Baltim	ore, MD 212	01		
St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signat		R.				
Regist	trar	HIN 2 9 2007	Marian D	CAN SERVICE					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / Bopt 1 - Registrar Ce	rtificate of Death	Reg. I	_ 2 U U /		
Г	Physicia	an	1. Decedent's Name (First, Middle, Last)			Day Year	3. Time of Death	
	/Medic	al	CATHERINE E. ANDERSON 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	JUNE 27	, 2007 4c. County of Death	6:25 A.M	
	Examin	ier	GILCHRIST CENTER	TOWSON		BALTIMORE		
ì	Funeral Director		5. Social Security Number 2 14-01-8594 Usual Residence of Decedent 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 7/8/1916	ar) Cou	place (State or Foreign intry) /LAND	
	iand ow		10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits	
	Mary a-f sh ified a	ctor	MD HARFORD JARRETI	SVILLE			1 ☐Yes 2XNo	
	ith the or 28a	Direc	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Cou	intry?	
	ath w	rall	1614 CYNTHIA COURT	21084		USA 14. Race - Ameri	ican Indian	
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show min injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√7 No	Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecity Yes of No- Rican, etc.)	Black, White	, etc.	
5	'2 hou latura ical E	ted	15 Decedent's Education 16a, Dece	dent's Usual Occupation	ing 16b.	. Kind of Business/li		
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מבוב	d be f ental f ced of	To Be	GEORGE T. SUMMERS		RINE E. BL	,		
<u> </u>	shoul ind Me i mark umati	Ě		ing Address (Street and Number or Ru			ip Code)	
Š	and 2 alth a				JARRETTSVI	LLE, MD	21084	
ย์	Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of ematory or other place)	Date 20c.	Location - City or T	Town, State	
Dallimor	Pag tment tant: I		4 □ Donation 5 □ Other (Specify) WESTERN			LTIMORE,		
ם	permit. Departr Importa any Inji	(c)		2. Name and Address of Facility TH			HOME, P.A. 1286	
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each it.		or respiratory arrest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	ntia			Jean	
	/Medical Examiner		Due to (or as a consequence ot):				<i>1</i>	
	ed sit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events					
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5	e law requires that the death cer has been signed by the attendin pe 2 should be detached for use	Physician/N	1 ☐ Yes 2 ☑ No 9 ☐ Unknown 5 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)				
7	requires that the een signed by the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?	
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VII	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? Hospital: 4 Description 2 DEP/Outration	Othor:	th (Check only one)		11	
0	ding Physician: The n. After this certificate ha funeral director, page	- T	27. Manner of Death 28a. Date of Injury 28b. Time of	TIL 3 DOA 4 Nursing H	ome 5 Residence		ity) (To spile	
SION	nding th. r: Afte e fune	ation	→ Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No				
DIVIS	l or Atter after dea Director	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Street City or Town, St	t and Number or Ru tate)	ral Route Number,	
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or i and manner stated.					
	ro the	Mec	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	n, Day, Year)	
	/		> If the this later up	D25205	T-	ne 27,	2007	
•	EX		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) A Charles S	1 0.14	- 1/21/	7070×	
)		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Mr Christo J	T. But	6 6 6		
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amenditem 8 per fh 9870 8-6-07 vt. State of Maryland / Department of Health and Mental Hygiene State State Registra Amend #30 Per DVR G868 6/29/Gertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** SAF₀ AZARYAYEV JUNE 26 РМ 2007 3:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6994 MILBROOK PARK DRIVE APT. 1-B BALTIMORE BALTIMORE | Months | Days | Hours | Min. | 8. Date (Birth (Mate), Day, Year) | 10/15/1915 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F AZARBEGEN 214-53-8332 Yrs Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show a or 28a-f show t be notified at 1 ☐ Yes 2 ☐ No Director BALTIMORE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a o aminer must be 6994 MILBROOK PARK DRIVE APT. 1-B by Funeral 21215 U.S.A. Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🕅 Married 1□Yes 2 No WHITE Baltimore, Maryland 21215-0036 Specify. 3 ☐ Widowed 4 ☐ Divorced "natural", er than "nature the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MANAGER RETAIL SALES 7 is marked other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be AZÁRYAYEV ျ ROSALIA UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 bother tra 1096 BASKERVILLE ROAD - REISTERSTOWN, MD 21136 ALBERT AZARIAH / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any Injury or o 1 X Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW 06/28/2007 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Celu 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Geriatric Failure Physician 199.000 /Medical Due to (or as a consequence of): Examiner rotein Calorie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Parkinssnis The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 1 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 1 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 ☐ Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. within 2 To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Alexande 0528/5

State Registrar

31. Date filed (Month, Day, Year) JUN 2 9 2007



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21208-3102

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Leonard Bengel, Jr. 07 5:15 a M 6 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Sosedale Center nare Hospital ranklin If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Jan 1997 | 997 | Social Security Number 214-01-2200 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) MaryTand 1**X**) M 2□ F 90 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Perry Hall 1 ☐Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8613 Jessica Lane 21128 USA Was Decedent Ever in U.S. Armed Forces? 1 2Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) diversity of work done during most of working life. DO NOT use retired) Machinist Bethlehem Shipyard Steel Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Leonard Bengel, Sr Catherine M. Lockwood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Nancy Pedersen-niece 8613 Jessica Lane-Perry Hall, Maryland 21128 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Moreland Memorial Park 6-29-07 Parkville, Maryland 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 8800 Harford Road Parkville,MD 21234 22. Name and Address of Facility EVANS, FUNERAL AND CREMATION 21. Signature of Funeral Service Licensee M: moral Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) neumonia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): (F FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 TYes 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes No 24a. Was an autonsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Sec 3□ DOA 1 🗌 Yes 2 ER/Outpatient 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 □ Yes 2 □ No investigation 2 Accident

Physician /Medical Examiner Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

a or

Director

Funeral

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Completed

Be

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death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after deat. Department of Health and Mental Hygiene. Important: If them 27 is marked other them any Injury or other traumany.

and attending physician for use as the buria been signed by the should be detached has this certificate

funeral After after death

Division or Vital Records, P.O. Box 68760,

or Attending Physician:

Physician/Medical Completed by Be P Certification:

Medical

3 ☐ Suicide

4 Homicide

(Check only one)

31. Date filed (Month, Day, Year,

JUN 2

9

within 24 hours a

To the Funeral I

filled in by

29b. Signature and title of certifier

and manner stated.

29c. License number D0065094

Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

Drive, Balto mD 21237

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who campleted cause of death (Item 23a) (Type, Print) 30. Name and address of person 4000

6 Could not be determined

Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1	For State Registrar
	December 41- 44

Certificate of Death

2. Date of Death

Physician /Medical **Examiner**

1. Decedent's Name (First, Middle, Last) Anna

Elizabeth

Boblitz

Month Day 2007 28, June

3. Time of Death 10:00A M

4a. Facility Name (If not institution, give street and number) 3211 O' Donnell Street

4b. City, Town, or Location of Death Baltimore

4c. County of Death N/A

Funeral

5. Social Security Number 213-32-8074 Usual Residence of Decedent 6. Sex 1 □ M 2 🕅 F 7. Age (In yrs. last birthday) 72

10c. City, Town or Location

If Under 1 Year | If Under 24 Hrs. Davs Months Hours

8. Date of Birth (Month, Day, Year) November 13,1934

 Birthplace (State or Foreign Country) Maryland

Director

r 28a-f show notified at

ms 23a or

th and Mental Hygiene.
7 is marked other than "natural", or Items traumatic event, the Medical Examiner mi

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic event

with the

death v

filed within 72 hours after

Baltimore, Maryland 21215-0036

10a. State Director Maryland 10e. Street and Number Funeral 11. Marital Status þ Completed Be (

N/A

Baltimore City

10g. Citizen of What Country?

1 XYes 2 □ No

10d. inside City Limits

3211 O'Donnell Street

1 Never Married 2 Married

12. Was Decedent Ever in U.S. Armed Forces? 2**X** No

21224 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

14. Race - American Indian Black, White, etc. Specify: White

3X Widowed 4 □ Divorced

1 □ Yes 2**X** If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

10f. Zip Code

1 ☐ Yes 2 ☐ No

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 6 years

College (1-4or 5+)

Housewife

17. Father's Name (First, Middle, Last)

Own Home 18. Mother's Name (First, Middle, Maiden Surname)

USA

Charles Anderson

Donna Lee Smith

23a. Part1. Enter the disease, o shock, or heart failure. Lis

21. Signature of Funeral Service Licenses

19a. Informant's Name/Relationship (Type. Print) Daughter

Margaret Graft 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1701 Elrino Street, Apt M. Baltimore, MD. 21224

Connelly Funeral Home Of Dundalk, P.A.

20a. Method of Disposition

1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Bayview Crematory

June 29 20c. Location - City or Town, State 2007

Baltimore City, MD.

Physician /Medical Examiner

sician and burial-trans

attending phys for use as the

sate has been signed by the page 2 should be detached

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine

Immediate Cause (Final disease or condition resulting in death)

7110 Sollers Point Road, Dundalk, MD. 21222 complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. and Neck

Interval Between Onset and Death 15 Months

Due to (or as a consequence of):

hvoat

Due to (or as a consequence of):

Due to (or as a consequence of)

23d. Date of delivery

1 Yes 2 No 3 Probably 4 Unknown

Physician/Medical

þ

Completed

Be

ပ

Medical Certification:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4□Pregnant at time of death

3 ☐ Ectopic pregnancy 5 Other (specify)

Month Day

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9☐Unknown

24a. Was an autopsy performe 1 Yes 2 No

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 No 27. Manner of Death

5 Pending investigation

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of (Month, Day Year)

28c. Injury at Work?

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

6 Could not be determined 4 Homicide

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Naturai

2 Accident

3 ☐ Suicide

1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year) June 29: 2007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

By von Baldwn P.A. ~ 3509 E0 3509 Eastern Ave. Beltimore, MD 21224

State Registrar 31. Date filed (Month, Day, Year) 2007 32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 24, $^{\text{Day}}$ 007 **Physician** Charles Joseph Bernat 3:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 142 Arthur Avenue Port Deposit Cecil 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (Sta March 26, 1931 Mary Tand 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1**7** M 2□ F Months 218-28-7604 76 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TYes 2 No **Funeral Director** Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2836 E. Ashland Avenue 21205 United States 12. Was Decedent Ever in U.S. Agned Forces? 1451 Yes 2□ No If Yes, Give Korea Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary (0-12) College (1-4or 5+) Fabricator Stee1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Bernat Vonasek Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon B. Barnes, Daughter 142 Arthur Avenue, Port Deposit, MD 21904 20b. Place of Disposition (Name of Wester, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Arundel Crematory June 27,2007 4 □ Donation 5 □ Other (Specify) Odenton, MD 21. Signature of Funeral Service Licensee M01113 Harman Funeral Service, PA 22. Name and Address of Facility 7221 Grayburn Drive, Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 months Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an autopsy performed? res 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Daughter's Residence Other: 4 Nursing Home 5 Residence 6 Hother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural (Month, Day Year) Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

/Medical **Examiner** ii or Attending Physician: The law requires that the death certificate be executed after death.
I Director: After this certificate has been signed by the attending physician and Division or Vital Records, P.O. Box 68760%the sate has been signed by page 2 should be detacl funeral director, filled in by within 24 hours af

To the Funeral D

completely filled i the

Baltimore, Maryland 21215-0036

Physician

State

Registrar

UNCULOGIST

29c. License number D0056919

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who dompleted cause of death (Item 23a) (Type, Print)

6701 N. Charles Street, Baltimore, MD 21204 Robert B. Donegah, MD

31. Date filed (Month, Day, Year) JUN 2 9 2007

(Check only

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 45 **Physician** Balle PM FODS Minise 23 /Medical 4b. City, Town, or tecation of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** The Johns Hopkins Baltimore NA Hosoutal If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2√□F 238-02-5932 50 Director 5-16-1957 N.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at Yes 2□No Director Md. NA Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a or : Examiner must be n 21213 1416 E. Preston St. USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Nurse Various 4 yrs. l and 2 should be filed v Health and Mental Hygie m 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shaw Bernard Martha Graham ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Williams Mother 1416 E. Preston St., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Bonation 5 ☐ Other (Specify) 5 Greenmount Cem. 6-28-07 Baltimore, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility March F.H. East 1101 E. North Ave., Baltimore, Md 21202 23a. Part1/Enter the disease, or complications that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, noc., or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm die e Cause (Final dise so or condition resulting in death) **Physician** Epidermal Necro 14515 TOXIC 7 day /Medical Due to (or as a consequence of) Examiner 9 months Duto or s a consequence of Sequentially list conditions, leave. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Human Immunodeficiency death certificate be execut the burial-tran Due to (or as a consequence of): physician use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe be a ģ 1 □ Yes 2**0**No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No To the Funeral Director: After this certific completely filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

Baltimore, Maryland 21215-0036

۵.

or Vital Records,

Division

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Data filed (Month, Day, Year)

medical Doctor

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Amy Delorn The Johns Hopkins Hospital

JUN 2 9 2007

29c. License number

Res

29d. Date signed (Month, Day, Year)

600 North welfe sweet Baltimore Mary and 21287